	1 - For State Registrar	State of Maryla	and / Depa		lealth and	Mental Hy	giene	40001
Physician	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month		3. Time of Death
/Medical	Mary K. Coate					Novembe	r 22, 2005	3:52P M
Examiner	4a. Facility Name (If not institution, g Suburban Hospit			4b. City, Town, or		th	4c. County of Deal	
Funeral			s. last birthday)	Bethes If Under 1 Year	If Under 24 Hrs	8. Date of Birt	Montgo	mery thplace (State or Foreign
Director	231-18-3262	1 □ M 2 □ XF	90 Yrs.	Months Days	Hours Min.			ountry) Virginia
and	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d, Inside City Limits
Maryi	Maryland Montgom		Silver S					1 ☐ Yes 2X No
n the	10e. Street and Number	LCL y	oliver r	10f. Zip Code			10g. Citizen of What Co	ountry?
th wit	1510 Hanby Stree	t		20902			USA	
6 after death with the Ma or terms 23e or 28e-fe orer must be rediffe. Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
336 irs afti	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ∑XNo If Yes, Give Year or Dates:	1	☐Yes 21x No	Specify:		Specify: Wh:	
121215-0036 led within 72 hours after death with the Maryland yygene. yygene. nt, the Madical Examinar must be notified at the Madical Examinar must be notified at Completed by Funeral Director	15. Decedent's	Education	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Business	/Industry
Med n	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done o OO NOT use retired	during most of wo d)	rking		,
L 21 lied w tygier nt, the	8	.)	Hom	emaker			Own Home	
and abe fill the south of the s	17. Father's Name (First, Middle, Las William Harry B					me <i>(First, Middl</i> e, a Jones	Maiden Surname)	
should Ind Meni	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a			r, City or Town, State, 2	Zip Code)
alth a strate	Julian H. Coates						ing, MD 209	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or items 23a or 28a-f show any injury or other than "natural; or items 27 is marked other than "natural; or items 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantural must be redifficed and once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from State		sition (Name of latory or other plac liven Cemete:	277	Date ember 26 005	20c. Location - City or	Town, State ing, Marylan
Salti ermit. Departm ny inju	21. Signature of Funeral Service Lice	ensee	Fr	Name and Addres	s Collins	Funeral	Home Inc	
403.00	23a. Party Enter the disease, or cor							Approximate
Box 68760, death certificate be executed e attending physicien and of for use as the buriat-transit clan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arrhythmia Due to (or as a conse Due to (or as a conse c. Due to (or as a conse d.	equence of):					Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (s <i>pecify)</i>			23d. Date of del Month	ivery Day Year
	Part II. Other significant conditions		sulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Cords cords w requires been sign should be	Clostridium Diff:	icile Colitis				1□Y	′es 2 ³ ⊡No 3⊟Pr	obably 4 Unknown
The The page						24a. Was a autop perfor 1 ☐ Yes	sy prior to med? death?	utopsy findings available completion of cause of 2 No
of Vita Of Vita Physician: This certified al director.	25. Was case referred to medical examiner?	Hospital:		_ Othe		ath Check only or	0.6	
on of V on of V ding Physi After this o funeral dire	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of	3 □ DOA □ Ulifo	4 □ Nursing F		ence 6 Other (Spe	cify)
Sion sath. or: Alter he funer	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ∐ No			
	3 Suicide 6 Could not to determined		home, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or Run, State)	ural Route Number,
MARY DI O the Hospital or o the Funeral Dir ompletely filled in	29a. Certifying P (Check only one) Certifying P ∠ Medical Exa	nysicien: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, death nation and/or invi	occurred at the timestigation, in my op	ne, date and place pinion, death occu	and due to the durred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
The state of the s	29b. Signature and title of certifier	ll_		29c. License D425	number 78	ż	29d. Date signed (Mont. November 2	
	30. Name and address of person who Gul Chablani, M.	D. 1119 Rock	ville P:	rint) ike, #401	, Rockv	ille, MD	20852	
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	H A	de				

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I			giene	Lnnn2
			Decedent's Name (First, Middle,	Last)		 	~	2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Salvador Josep	h Cosimano,	Jr.			Novembe	er 18, 20	005 3:15 AM
N. C.	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death	1	4c. County of	Death
			Renaissance Gard					0.5	Montgom	
	Funeral		,	5. Sex 7. Ag 1XД M 2 ☐ F	e (In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		578-10-1943 Usual Residence of Decedent		83			Mar. Z	/, 1922 W	lashington, DC
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Ma	cto	Maryland Montgom	ery	Silver Sp	ring				Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen ol Wh	at Country?
	death with the Maryland me 23a or 28a-f show rrust be nullified at	ra	3146 Gracefield		5	20904			U.S.A.	American Indian,
	ter de Item	Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces?	Not /15 /10/4	If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	o Rican, etc.)	Black,	White, etc.
980	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	№4/15/1946 1/13/1949	1☐ Yes 2⁄☐ No	Specify:		Specify:	White
21215-0036	72 hours after natural', or Ite	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	nation during most of wor	king	16b. Kind of Busin	ness/Industry
21	within 7 ene. then "r	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retire	d)	anig		
21	ygien ygien her th			5+	Gener	al Surge		(5:	Medical	. , ,
and	be fill be fill be fill be fill be fill be ad ott	Be	17. Father's Name (First, Middle, L.				18. Mothers Nan	ne (<i>FIIS</i> T, MIdale,	Maiden Sumame)	
ž	12 should be filed within h and Mental Hygiene. 7 le markad other then " treumatic event, the Me.	ပ္	Salvador Joseph 19a. Informant's Name/Relationshi			ing Address /Street	Angelo C		er, City or Town, St.	ate Zio Code)
Maryland	th an treum		Alice F. Cosiman							ng, MD, 20904
ē,	thealth rem 27 other to		20a. Method of Disposition	o / Wile	20b. Place of Disp			Date	20c. Location - Ci	
Ë	Pages nent of l int: If it		1 ☑ Burial 2 ☐ Cremation : 1 ☑ Donation 5 ☐ Other (Spe		Gate of H	-	I NOV.	05^{22} ,	lilver Sn	ring, Maryland
altimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If Item 27 to marked other then "natural, or Iteme 23e or 28e-f show any injury or other treumatic event, the Medical Exercities must be notified at once.		21. Signature of Funeral Service Li					seph Gav	vler's So	ns, Inc.,
m	8 3 E 8		Joen Wright	ld Joshin	5	130 Wisco	onsin Ave	. N.W. V	Vashingto	n, D.C. 20016
Г			23a. Part1. Enter the disease, or co shock, or heart lailure. List o	omplications that cause nly one cause in each li	d the death. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Meta	static -	MILLAMD	+ Cell	Accus	ma	2 Monit
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):					
ķ.		35	Sequentially list conditions if any, leading to immediate	b. Due to (or as	a consequence of):					
	nsit	Examiner	Cause (Disease or injury							
Ć,	execun and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):					=
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	cal		d						
9	ntifica ng ph s as th	Physician/Medical	IF FEMALE:							
Вох	eath certific attending p I for use as I	an/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic pregnanc	у		23d. Date of	,
O.		/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (specify) _			111071	. Day
Δ.	that the de led by the a detached t		Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause or	ven in Part I.	23e. Did to	obacco use contribi	ute to the cause of death?
Vital Records,	88 56 B	d by	·	J	· ·	, , ,		1 🗆 \	res 2□No 3	☐ Probably ☆ Unknown
CO	w requir been si should I	lete						24a. Was	an 24b. We	re autopsy findings available
Re	The lav	Completed				···		autop perfo	osy prid rmed? dea	or to completion of cause of ath? I Yes 2 □ No
ital		0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1165 2 140
>	S 0 =	To B	examiner? 1 ☐ Yes 2☐No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatie	nt 3 DOA	ner: 40X Nursing H	ome 5 Resid	dence 6 Other	(Specify)
n of	ding Phy th. After thi funeral c		27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	ay Year) 28b. Time o	Wo	rk?	28d. Describe h	now injury occurred	
Sio	Attending of death. sctor: After by the fune	cati	2 Accident investiga	ation			Yes 2□No			
Division	l or Attendatter deatl	Certification;	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of in	jury - At home, larm, st tc. <i>(Specify)</i>	reet, lactory, office		28f. Location (S City or Tox		or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physician: To the best	of my knowledge, dea	th occurred at the ti	me, date and place	and due to the	cause/s) and mann	or ac stated
	24 h	edical	(Check only one) 2 Medical E	xaminer: On the basis of and manner st	of examination and/or in	nvestigation, in my	opinion, death occu	rred at the time,	date and place, and	d due to the cause(s)
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier	1, 1		29c. Licen:	se number		29d. Date signed	Month, Day, Year)
	7.0		Mea wh	eshit		0004	13375		11/18/00	5
	LU		30. Name and address of person w	nho completed cause of						
	2		Karen Merritt,		Gracefield	, Silver	Spring,	Maryland	1 20904	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	parke				
	negisti	CII .	1404 20	C003	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b, perFH, G850, 12/20/05 TT
State of Maryland'/ Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:15 A M Beatrice Creeger November 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 669 Wilson Road Rising Sun Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖫 F June 28, 78 1927 Oxford, Director 179-22-3574 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or frams 23a or 28a-f ehow the Medical Ever ther must be notified at 1 ☐ Yes 2 👿 No Completed by Funeral Director MD Cecil Risina Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 669 Wilson Road 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hyglene.
ant: If Item 27 Is marked other than "natural; or Ital
any or othar traumatic event, Item Medical Eventinal ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Greenhouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Gill Annie McCrearu 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 669 Wilson Road, Rising Sun, MD William D. Creeger/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If Its any injury or or once. 1 Burial 2 Cremation 3 Removal from State 11-18-2005 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery Rising Sun, MD 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licenser 111 S. Queen Street, Rising Sun, MD 21911 chang 23a. Part | Enter the disease, or complications that cau - the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cycle on ear line. Approximate Interval Between Onset and Death Immediate Cause (Final tai Priysician espivatory disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner death certificate be executed Cause (Disease of Figure that initiated events resulting in death) Last burial-transi thing Due to (or as a conseque ce of): attending physician for use as the burial P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 🗓 🗷 o 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 pertension ormed? 212 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Innatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending Injury 1 Yes 2 No death. investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funaral E 29a. Certifier 1 Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Pate signed (Month, Day, Year) 29b. Signature and title of Partifle 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S 1 hresher V 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NUV 2 8 2005 vare Registra

		1		Maryland`/ Depa		ealth and N		CHIL	40004
*	Physicia	an	1. Decedent's Name (First, Middle, Last) Ruth Dillow				2. Date of Death November	23,2005 ^{ar}	3. Time of Death 9:57pm M
\$ 100 mg	/Medic Examin		la. Facility Name (If not institution, give street and numb Shady Grove Medical Cen		4b. City, Town, or Rockv	Location of Death		4c. County of Death Montgome:	
	Funeral Director		231-66-4171 1□M 2□XF	Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth April 28	9. Birth Sal	place (State or Foreign Wille, VA
	aryland show	1 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits 11 Yes 2 □ No
	vith the M	Directo	MD Montgomery 10e. Street and Number 16100 Crabbs Branch Way #		10f. Zip Code 20855		_	Citizen of What Cou Jnited St	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28a-f show amy injury out-other traumatic event, the Meulcal Examinar mind be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Sign Sirve S	nnt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:		14. Race - Ameri Black, White Specify:	ican Indian, , etc.
Maryland 21215-0036	within 72 houriene.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	16a. Dece (Give life.	dent's Usual Occup o kind of work done o DO NOT use retired emaker	during most of world	king	Kind of Business/In	White ndustry
land 2	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Curtis Lee Hopkins Jr.	<u> </u>		18. Mother's Nam Rosa Ta	e (First, Middle, Maid albert	len Sumame)	
Mary	nd 2 shoralth and N 27 Is ma		19a. Informant's Name/Relationship (Type, Print) Claude Dillow/ Husband				ral Route Number, Ci ny #24,Der		
Baltimore,	ages 1 a	ĺ	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place Heaven C	1		Location · City or T ilver Spr	
Baltin	permit. F Departm Importer any inju		21. Signature of Funeral Service Lice	2	2. Name and Addres	ss of Facility OS	eph Gawler N.W. Wash	's Sons,I	NC
19	Physician		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac Immediate Cause (Final disease or condition	sed the death. Do not en h line.		g, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):			V		
4	ecuted and -transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):					
68760,	aath certificate be executed attending physicien and for use as the burial-transit	cal	d	as a consequence or).					
P.O. Box 6	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med		h 2 ☐ Fetal death 3 [nt at time of death 5 [□Ectopic pregnancy □ Other (s <i>pecify)</i> _			23d. Date of deliver Month	very Day Year
	w requires that been signed b should be det	ed by P	Part II. Other significant conditions contributing to dea	th but not resulting in the t	underlying cause giv	en in Part I.		co use contribute to	the cause of death?
Records,	The law re- te has bee age 2 sho	Completed by	Clostridium diffici gastrointestinal hemor	le colitis			24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
of Vital	certifice rector, p	Be	25. Was case referred to medical examiner?	patient 2 ER/Outpatie	ent 3 DOA Oth	er	th (Check only one) ome 5 Residence		
ion of	Attending Physic death. sector: After this by the funeral di	atlon: To	27. Manner of Death 1		of 28c. Injur Wor	y at	28d. Describe how		ay)
Division		Certification:		f Injury - At home, farm, si g, etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stree City or Town, S		ral Route Number,
	he Hospital or in 24 hours afte he Funeral Dir pletely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	is of examination and/or in	th occurred at the time	me, date and place opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
•	i	2	29b. Signature and title of partier	ohni	29c. Licens	2014-8		Date signed (Month	24, 2005
	Q		30. Name and address of person who completed cause Staven H. Dolinsky, M.D.	9901 Shady G	Grove Rd.,	Rockvil	le, MD 20	850	
Part A	St Regist	ate rar		gistrar's Signature	parte				

			For State Registrar	State of	Maryland	/ Depa		t of H	ealth a		lental Hy	giene Reg. No.	05	40005
	Physicia /Medic Examin	al er	1. Decedent's Name (First, Middle, Lat- Joseph Lat- 4a. Facility Name (If not institution, give NORTHWEST HOSPITA	CON street and numi			-		Location o		2. Date of De. Month	ER 2 4c. C	Year 3 200 County of Dec	5 11:10 M
	Funeral Director		210 03 0313	ex XXM 2□F	. Age (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da MAY 18	, Year) , 191	9. B	irthplace (State or Foreign Country) ARYLAND
	ter death with the Maryland Itams 23a or 28a-f show Iner Gust be notified at	Irector	Usual Residence of Decedent 10a. State 10b. County MARYLAND CARROL 10e. Street and Number	L		Town or Lo		Code				10g. Citize	en of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No Country?
100 21215-0036	ould be filed within 72 hours after death wi Mental Hygians natural; or Itams 23a i sarked other than "natural; or Itams 23a i natic evant, the M. of cal Ex. infiner intest b	To Be Completed by Funeral Directo	7309 SECOND AVENU 11. Marital Status 1XXever Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Encycle only highest grade in the second secon	12. Was Deced Armed Ford NF Yes 2 If Yes, Give Year or Dail ducation Ide completed)	es: WWII	16a. Dece (Give life.		No al Occupa rk done d se retired	spanic Orin, Mexicar Specify: ation during mos	t of work	acify Yes or No Rican, etc.) ing a (First, Middle, JANE HI	16b. Kind	Black, When Black,	nerican Indian, nite, etc. BLACK
re, Mar	is 1 and 2 sh of Health and item 27 Is m other traum		19a. Informant's Name/Relationship (MELVINA TURNER/N 20a. Method of Disposition WYBurial 2 Cremation 3	IECE Removal from S	20b. Pla cer tate MD X7	808 ce of Disponetery, cre	WILDW osition (Name matory or o	OOD ne of ther place	PARKV	VAY, 12/d	BALTIMO	ORE,	MD 2 ation - City o	, Zip Code) 21234 or Town, State
Baltimore,	permit. Page Department of Important: If any Injury or once.	اسر	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	y)	ک در ح	_ 2 V	2. Name an IYERS—	d Addres	s of Facili	y FUNI	ERAL HOI WESTMII	ME. P	.A.	21157
8760,	Icate be executed /Medical bhysician and Examiner sthe burial-transit	dicai Examiner	23a. Pag. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any Leann Dimmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to c	or as a consequence as	ence of):	He R	50			or respiratory a	rrest,		Approximate Interval Between Onset and Death
O. Box 6	death certif e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 ☐ Fetalo ant at time of dea	death 3	⊒Ectopic pr ⊒ Other (sp					23	3d. Date of d Month	lelivery Day Year
Records, P.	v requires been sign should be	Completed by Pl	Part II. Other significant conditions	•		ting in the t	underlying c	ause gre	en in Part I	<i>.</i>	1 🗍 24a. Was auto perfo	Yes 2 an psy ormed?	No 3 🗆	autopsy findings available o completion of cause of
Division of Vital Records,	ding Physician: n. After this certifica funeral director, p	Certification; To Be C	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not to determine determined	28a. D te o (Monti	npatient 2 E f Injury n, Day Year) of Injury - At hon ng, etc. (Specify)	28b. Time o Injury	of 2	28c. Injur Wor 1 🗆	er: 4□Nu yat	ursing Ho		one) dence 6 how injury	Other (Sp	
	To the Hospital or Attent within 24 hours after deall To the Funeral Director.	Medical C	29a. Certifier (Check only one) 1 Certifying P 1 Medical Example of Certifier 29b. Signature and title of Certifier	hysician: To the miner: On the ba and mann	sis of examination	on and/or in	1vestigation	c. Licens	ne, date ar pinion, dea e number	ath occur	red at the time,	date and p	place, and d	ue to the cause(s) onth, Day, Year)
	141011	ate rar	30. Name and addr s of person who are filed (Month, Day, Year) NOV 2 8	105 PITIAL 32. RE	CEINT egitrar's Signatu	ire .	Print) J	Mão NOV	OER	₽ W	DEHTA V	m.0	5401	old Court &c.
DH	MH 17 Rev 1/2	2001		-			1							

State of Maryland / Department of Health and Mental Hygiere 0 0 5

			1 - For State Registrar Certificate of Death	Reg	. No.	10000
		m		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Evelyn Delores Derossett	November	23 2005	6:50A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	_
			Carroll Hospital Center Westminster		Carrol	
l	Funeral Director		216-50-1045 1 M 2 F 58 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, Y) July 8,19	9. Birth Cou West	place (State or Foreign ntry) Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary f sho	ţ	W. VA Morgan Berkeley Springs			1 ☐ Yes 2 ☐ X No
	1 the	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	ntry?
	th with		7444 Martinsburg Rd. 25411		U.S.A.	
	ema erma	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Specific	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any figury or other traumatic event, the Medical Examinat must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Consitu	hite
ה	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Sive kind of work done during most of workin life. DO NOT use retired)	ng 16	b. Kind of Business/Ir	dustry
V	within sne. then	dm	Elementary/Secondary (0-12) College (1-4or 5+) 2 Cashier		gas sta	tion
7	Hygie ther ther		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma.		
and	id be ental ked o	To Be	Donnelley Hollobaugh Evelyn		,	
3	shoul nd Mi	F	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rura</i> .		City or Town, State, Zij	code)
Ĕ	alth a		Laura Jones/ daughter 1524 Old New Windsor Ro	d. New V	Windsor, M	D 21776
e,	of Heror	1			c. Location - City or T	
Ē	Page ment in		All County Cremation 11/26			, MD
Банттоге	permit. Departr Importu any inju		21. Signify e of Edneral Service Licensee August 22. Name and Address of Facility Harman Address of F			6
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition as Atherosclevotic Cardio va.	00.10-	Diene	Onset and Death
	/Medical		resulting in death) a. ITTUEVOSCLEVOTIL CAVAID Va Due to (or as a consequence of):	SLOIDE	Disease	1ears
	Examiner		Sequentially list conditions b.			
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
	and and I-trans	хаш	Cause (Disease or injury that initiated events c			
Ď,	certificate be executed nding physician and use as the burial-transit		Substitution (in the contradiction of),			
08/00	ficate phys s the	Medical	d			
_	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery
20	w requires that the death cer been slgned by the attendin should be detached for use	hysician/	in the past 12 months? 1 Ves 2 M No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
5	the the by the tache	hys	9 Unknown			
ŝ	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to	
ecora	equir sen sl ould	ted	Cerebrovase vlar Accidents	1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
ပ္	law r las be	Completed	Renal Insufficiency	24a. Was an autopsy	24b. Were auto prior to co	opsy findings available ompletion of cause of
<u> </u>	The law	Con	,	performe 1 ☐ Yes 2	d? death?	
VItal	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	(Check only one)		
0	Physician: r this certific ral director,	٦.		me 5 Residence 28d. Describe how	e 6 ☐Other (Speci	fy)
	ffe on	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	200. Describe now	injury occurred	
DIVISION	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not be 28e Place of Injury - At home farm, street, factory office		et and Number or Rur	al Route Number,
2	spital or Attanding Physicus after death. Internal Director: After this filed in by the funeral di	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, S	State)	
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a complex one one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a complex one one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, and the death occurred at the time, date and place, a complex one of the death occurred at the time, date and place, and the death occurred at the time, date and place, and the death occurred at the time, date and place, and the death occurred at the time, date and the death occurred at t			
	ompk	Me	29b. Signature and title of certifie 29c. License number	29d	I. Date signed (Month,	Day, Year)
			> Plan Kolmer MN DMF D37197		11-23-	2005
	WIL		30. Na e and address of person who completed cause of death (Item 23a) (Type, Print)	e Esta A		
_			Han Robrer, MD 15 West 7th Street	Trest	nek M	2005 DZ170
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regignar's Signature			
		P-16	and the first of the first than the			

			1 - For State Registrar		State of Ma	ırylan				lealth a	ind M		Reg. No		5 4	00	07
	Physici	20	Decedent's Name (First, M.			_						Date of De Month	ath Da	y	Year	3. Time o	
	/Medic		Donovan		een	De	entinge					DECEMBI			2005	14	35 M
100	Examin	er	4a. Facility Name (If not institu		street and number)			4b. Cit	, Town, or	r Location o	f Death			. County o			
1	*		MEMORIAL HOS 5. Social Security Number	PITAL 6. Sex	7 Age	/In vrs	last birthday)		BERLA er 1 Year	ND If Under 2	24 Hrs.	8 Date of Birt		LLEGA		ace (State	or Foreign
4	Funeral Director		214-07-4274		M 2□F 8		Yrs.	Month:		Hours	Min.	8. Date of Bird Month, Da OCt 5,	1918	3	Count	D (Siate	or Foreign
	105		Usual Residence of Decedent						<u> </u>			0000,					
	how		MD All			10c. City	y, Town or Lo		~ d						10	d. Inside (•
	B Ma	cto	ווא טועו	egany			Curric	Clia	iu							¹X□ Yes	2 No
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show entry injury or other treumatic event, the Medical Examinant to another and once.	by Funeral Director	10e. Street and Number 12122 Lotus A		_			10f. Z	ip Code	21502			10g. Cit	izen of W	hat Count	ry?	
	e 23s	era			12. Was Decedent E	Ever in 11	C 13	Was Doo			rin2 /Sn	norty Vas or No	_		- America	n Indian	
	Item Item	Ę.	11. Marital Status 1 ☐ Never Married 2 ☐ N		Armed Forces?					an, Mexican	, Puerto	ecify Yes or No Rican, etc.)	•		, White, e		
99	al', or	by	3 Widowed 4 □ Divor		ty Yes 2 □ N If Yes, Give Year or Dates:	WW II		1 🗆 Yes	2 No	Specify:				Specify:	white		
Š	2 hou	ted	15. Dece	dent's Edu	cation		16a. Dece	dent's Us	ual Occup	ation	-4		16b. K		siness/Indi		
215	hin 7	pie	(Specify only his Elementary/Secondary (0-1		College (1-4or 5	+)			use retired	during most d)	or work	ing					
7	er th	Be Completed	12				labore	er						anes			
<u>n</u>	ould be filed v Mental Hygie tarked other t tatic event, th	Be	17. Father's Name (First, Mide William S. E		aer							e (First, Middle, Green De)		
<u>X</u>	Men	P															
Maryland 21215-0036	12 sh hand 7 le m rreum		19a. Informant's Name/Relati	onship <i>(Ty</i> DIdS	pe, Print) nephe	ew	19b. Maili	ng Addre 14 Yu	ima S	and Numbe Street	s or Rur SW	Route Number	erla	or Town, S nd	State, Zip (MD	ິ2150	2
e,	1 end Healt em 2 ther		20a. Method of Disposition		•	20b. P	lace of Dispo	sition (N	ame of	I		Date			City or Tov		
Baltimore,	ages nt of nt of t: If it		1 Burial 2 □ Cremati		emoval from State	Sun	emetery, crei set Mem	natory or Iorial	other place Park	(e)		12/9/2005		mber	•		1D
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Ba	Deperment of the concession of		>/1////	7	J	11						me, PA Cumber	and	MD 2	1502		
			23a. Party. Enter the disease shock, or heart failure.	, or compli	cations that caused	the death	n. Do not ent							IVID Z		Approxima	ite
	Physician		Immediate Cause (Final	List only or			,									Interval Be Onset and	Death
X.	/Medical		disease or condition resulting in death)	-	Due to (or as		Onic	<u> </u>									
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Ļ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•	Due to (or as t	e consaq	aence of):								= =		
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Ó,	cate be executed physicien and the burial-transit	Ä	resulting in death) Last		Due to (or as	a conseq	uence of):										
8760,	ate b hysic the bi	licai			i												
9	e as t	Physician/Med	IF FEMALE:	11.												- /	
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	2	3c. If yes, outcome 1☐Live birth	2 🗌 Feta	Ideath 3		pregnancy	,				23d. Date Mon	of deliver	y Day	Year
<u>o</u>	the e	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 Pregnant at 9 Unknown	time of di	eath 5	Other (specify)							,	
σ.	Attending Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the ettending physicien and bette tuneral director, page 2 should be detached for use as the burial-transit.		Part II. Other significant con	ditions cor	ntributing to death bu	ut not resi	ulting in the u	nderlvina	cause give	en in Part I.		23e, Did t	obacco	use contri	bute to the	a cause of	death?
Records,	sign d be	d by					•	, ,				10	Yes 2	□No :	3 ☐ Proba	ibly 4	Unknown
Ö	w requir been si should	Completed										24a. Was		24b W	lara auton	au finding	- available
Rec	has ge 2	d L							-			autor		pr	rior to comeath?	sy findings pletion of	cause of
a	ician: Th certificete ector, paç		25. Was case referred to med	lical						00 01	-4.0	1 Yes	2 1 No	11	☐ Yes 2	2□ No	
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o	arthis eral c		27. Mangrer of Death		28a. Date of Injur (Month, Day		28b. Time o		28c. Injun Worl	4 (1441		28d. Describe				<u> </u>	
ion	nding Ith. r: Afte	atio	1 ☑Natural 5 ☐ Pe 2 ☐ Accident inv	nding estigation	(Month, Da)	rear)	Injury	М		k? Yes 2 □1	Vo						
Division of Vital		iii Ca		uld not be ermined	28e. Place of Inju- building, etc	iry - At ho	ome, farm, sti	eet, facto	ry, office			28f. Location (S			r or Rural	Route Nu	nber,
	0 = 0 =	Certification:	4		Dulldling, etc	(Specin)	*/					City of 10	Wi, State	9/			
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Cert	fying Phys	sician: To the best oner: On the basis of	of my kno	wiedge, deat	h occurre	d at the tin	ne, date and	d place,	and due to the	cause(s) and man	ner as sta	ited.	c)
	To the H within 24 To the F complete	Medical	one)	1	and manner sta	ted.											٥/
	To To To	2	29b. Signature and title of cer	titier				2	9c. Licens	e number			_		(Month, E		
	Δ		(100	hm/ Z				D	36766			D (0)	en)	t re	,20	0.5
	1		30. Name and address of per							ara	D.T. C.	,	1155	0			
	- L. L.		POONAI, VIKRA	AMADI'	I'YA M	924	4 SETO	N DR	LVE.	CUMBE	KLAN	וט, MD 2	2150	2		n etc.	
***	Sta Regist		31. Date filed (Month, Day, Y	12 20	32. segistra	Sul 1	S. A.	MAKE.									

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JAMES P.	DAVIS	,	J	R.
05-07788		•		
RJ	-			For
		1		For State

	\$8		1 - For State Registrar Amened item	State of Man #12 per										5	Lanns
7 2	n 90%		1. Decedent's Name (First, Middle, La		•						2. Date of D Month	eath		(3. Time of Death
	Physici /Medi		James Patrick Dav	is, Jr.							Novemb	oer 1	8, 20	005	6:54 p. [™]
	Examir	-	4a. Fecility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		-	County of		
	8	9	Peninsula Regiona					list			,				ounty
	Funeral			6ex 7. Ag 18 M 2□ F 58	je (In yrs. last b	Yrs.	If Under Months	1 Year Days	If Under:	Min.	8. Date of Bi (Month, D	ay, Year)		9. Birthpl Coun	lace (State or Foreigi try)
.50	Director		218-46-0838 Usual Residence of Decedent	- 50		113.					June 2	9,194	47	Mary	land
	land		10a. State 10b. County	** <u>***********************************</u>	10c. City, To	wn or Lo	cation							11	Od. Inside City Limits
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	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or iteme 23a or 28e-f ehow other treumatic event, the Madical Examinations the notified at	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wh	at Coun	try?
	th wit		7529 Zion Church	Rđ.			2	1849				IISA			
	dea dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.			spanic Orig	gin? (Sp	ecify Yes or N Rican, etc.)		14. Race	America White,	
ð	or it	y Fu	1 Never Married 2 Married	1 X Yes · 2-X	No -		1 ☐ Yes		Specify:	, , , , , , ,	,		Specify:	***********	510.
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77	withi ene.	mc	Elementary/Secondary (0-12)	College (1-4or	5+)		umbei		,			Dl	mbin	~	
2	Hygir other	Be C	17. Father's Name (First, Middle, Last)			- unoci	_	18. Mothe	er's Nam	e (First, Middle				
Maryland	uld be Mental rrked c	To B	James P. Davis S						Hatt	io S	hortri	AGC.			
a√	shou and M mar	-	19a. Informant's Name/Relationship		19	9b. Mailir	ng Address	(Street a			al Route Numi		or Town, Si	tate, Zip	Code)
	1 and 2 Health a tem 27 ic		Jennifer McCulley,	/Daughter	3	2227	Perr	cyhav	vkin 1	Rđ.	Prince	ss Ar	ne M	21	853
ē,	of Heri		20a. Method of Disposition		20b. Place	ot Dispo		ne of			Dat <i>e</i>	20c. Lo	ocation · C		
Ë	Page nent o int: if		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Maryla				ce less	11/	/28/200	5	Hurlo	ck A	Maryland
Baltimore,	permit. Pages Department of I important: if its eny injury or of once.		21. Signature of Funeral Service Lice	ns+y	· ····································	⊔ 22	Name an	d Addres	s of Facilit	Y 77-	me, P.A			0.17.	-d-12dilo
n	Depa impo eny i		Kell K	perme	(F56						lisbury		2190	24	
			23a. Part1. Enter the disease, or comshock, or heart tailure. List only	plications that cause	d the death. Do	o not ent	er the mod	e ot dying	g, such as	cardiac	or respiratory	arrest,	~210	7-1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Atherwo							Ser-				Onset and Death
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X Q Q	death certifica e attending phi id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal dea		Ectopic pr						23d. Date Month		ry Day Year
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7	requires thet the leen signed by th hould be detache		Part II. Other significant conditions	contributing to death b	out not resulting	in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco (use contrib	ute to th	e cause of death?
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0	g Phys ter this neral di	i.i.	27. Manner of Death	28a. Date of Inju (Month, Da	ury 28b	. Time of		8c. Injury Work			28d. Describe				,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	U.10)	and manner st	tated.										
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	12.83		Monte	They	ull 11	(N)								,	
1	1/6		30. Name and address of person who			а) (Туре,	Print) 1]	l1 P€	enn St	tree	t Balt	imor	e, Ma	ary1a	and 21201
	, ,		31. Date filed (Month, Day, Year)	N. KOREU	rarie Signatura										
1	St. Regist	ate rar	NOV 2 3	2005	rar's Signature	, ,	-								
DH	MH 17 Rev 1/2	2001		A CAR	isse st.	Adj	THAT L	/						_	

			For State Registrar	State o	f Marylar	•	artment of H tificate of L			ene g. No.	5	40009
C	Physici	an	1. Decedent's Name (First, Middle, Las	st)					Date of Death Month		Year	3. Time of Death
	/Medic		Thomas Theodore						November			8:00 P ^M
Ţ.	Examin	er	4a. Facility Name (If not institution, give		mber)			Location of Death		4c. County o		
			Suburban Hospita 5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	Bethesd If Under 1 Year	a If Under 24 Hrs.	8. Date of Birth	Montg		y lace (State or Foreign
	Funeral Director			₩ 2□F	79	Yrs.	Months Days	Hours Min.	(Month, Day,		Coun	itry)
	ט		Usual Residence of Decedent						Nov.1,	1920	New	York
	nylan ihow		10a. State 10b. County		10c. C	ty, Town or Lo	cation				10	Od. Inside City Limits
	Be-f	cto	Maryland Montgo	nery		Bethe	sda					1 ☐ Yes 2½ No
	or 2	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	hat Coun	try?
	s 23s	ra	6005 Marquette Ter		edent Ever in U	16 40 1	208			USA		an Indian,
9	be filed within 72 hours after death with the Maryland stal typiene. Identify then "ratural", or items 23a or 28e-f show other than "ratural", or items 23a or 28e-f show event. The Medical Examinar must be multiled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Fo 1 ∰ Yes If Yes, Gir Year or D	orces? 2 No ve		Vas Decedent of Hi f Yes, specify Cubai I □ Yes 2☑ No	spanic Origin? (Spon, Mexican, Puerto	Rican, etc.)		, White, e	etc.
9200-91212	2 hou		15. Decedent's Ed	lucation	WWI	16a. Deced	lent's Usual Occupa	ation	1	16b. Kind of Bus		ite dustry
2 -	n n	Completed	(Specify only highest gra	de completed) College (1-40r 5+)	(Give life. L	kind of work done d OO NOT use retired,	luring most of worki)	ing			,
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2	be filed ital Hygind of other event, I	Be (17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle, N	faiden Sumame)	
Maryland	ould be Mental arked c	၉	Maurice A. Ernst						. Ganey			
Ja	2 sh		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ig Address (Street a	and Number or Rura	al Route Number,	City or Town, S	State, Zip	Code)
e O	teelit Person		Cecille A. Ernst	Wif		6005 N	Marquette	Terrace		la Mary l		
Baltimore,	permit. Pages 1 end 2 should be to Department of Health and Mental I Importent: if I tem 27 ie marked ot any nlury or other traumatic even ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		01-1-	cemetery, cren te of I	natory or other place		mber 28	cuc. Location - C	Jity of To	wn, State
	t. Pa		4 Donation 5 Other (Specific		Ga		Cemetery		005 51	lver Sp	ring	,Maryland
e n	Depare		21. Signature of Funeral Service Licer	ISEE	0	Fra	Name and Addres	Collins F	uneral H	Home, Ir	ıc.	
			23a. Part 1. Exter the disease, or com	nlications that of	caused the ca		00 Univer				ring,	MD 20901 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on e	each line.	50 1101 0111	or the mode of dying	9, 02011 03 02.0100	or respiratory arro			Interval Between Onset and Death
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o,	exec an an rial-tr	Examine	resulting in death) Last		(or as a conse							o years
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9		0	IF FEMALE:									
ХOЯ	death certific e attanding pl d for use es t	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live t	tcome of pregn birth 2 Tet	al death 3 ☐	Ectopic pregnancy			23d. Date Mon		ry Day Year
0	at the dea by the a tached for	sic	1 Yes 2 No	4∐ Pregr 9□ Unkn	nant at time of	death 5□	Other (specify)			William		ouy Tour
٦.	het th od by detacl	F.	Part II. Other significant conditions of	ontobuting to d	leath but not re	sulting in the ur	nderwing cause give	on in Part I	23e Did tob	acco use contri	bute to th	ne cause of death?
Hecords,	law requires thet as been signed b 2 should be deta	d b	Chronic Obstruc	-		-						ably 4 □Unknown
Ö	w requ	Completed	Onionie obserue	CIVE I	armonar	y DIBCC	100		-			
ĕ		ם	*						24a. Was an autopsy perform	1 245. W / pr led? de	rere autor rior to con eath?	psy findings available appletion of cause of
ā	n: The ficate h rr, page								1 ☐ Yes 2	⊠ No 1	Yes	2□ No
of Vital	Physician: Tribis certificatral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	3.50/Outpation	Othe	26. Place of Death			. (0 (
ō	y Physical this eral di	7. To	27. Manner Death		of Injury oth, Day Year)	28b. Time of			me 5 Reside			7
<u> </u>	nding F Nh. r: After e funera	at lo	1 Patural 5 ☐ Pending 2 ☐ Accident investigation		ith, Day Year)	Injury		(? Yes 2 ☐ No				
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ā	s effer el Direc ed in by	Certification:	4 _ Homede	Dund	ing, etc. (Speci	(Y)			City of Town,	, State)		
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier 1 ☆ Certifying Ph (Check only one) 2 ☐ Medical Exar	niner: On the b	e best of my kn pasis of examin nner stated.	owledge, death ation and/or inv	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and man ite and place, a	ner as stand due to	ated. the cause(s)
	To t withi To tl	Σ	29b. Signature and title of certifier	11	111	15	29c. License	number	29	d. Date signed	(Month, I	Day, Year)
	124)	the	16	Ull.	D 1	11921	No	vember	24,2	005
	1 "		30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type.	Print)					
			John A. Galotto	M.D.			11 Road I	Bethesda,	<u>Marylan</u>	d 2081	4	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 28	2005	gistrar's Sign	ature	ande					

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		•	For State	State of Ma	ryland / Depa	artment of F rtificate of I		, ,	2005	1.0010
	300		Registrar 1. Decedent's Name (First, Middle, Last)		Cel	lilicate of	Dealii	2. Date of Death	JANO.U U U	3. Time of Death
*	Physici	an		D - 4-4 M				Month	Day Year	M
1 1	/Medic		4a. Facility Name (If not institution, give s		ie Ferguso		r Location of Death	November	26, 2005 4c. County of Dea	
*	Examili	iei Č	Citizens Nursing H			Freder			Frederic	
130	Funeral	F 5 6 6 7	Social Security Number	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)		thplace (State or Foreign
#	Director		224-76-7306	M 2[XF	56 Yrs.	Months Days	Hours Min.	July 31		ginia
5	120		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	peation				10d. Inside City Limits
2	ol a	5	MD Frederick		Frederic					1 ☐ Yes 2 ☑ No
ئ م	288-	Director	10e. Street and Number		Trederie	10f. Zip Code		100	g. Citizen of What Co	
3	0 2	ā		•				100		ountry :
5-0036	"netural", or items 23a or 28a-f show adical Examinat must be notified at	Funeral	5923 Dorsey Driv	12. Was Decedent B	Ever in U.S. 13.	21703 Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	USA 14. Race - Ame	
က္ခ်	른불	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo			Rican, etc.)	8lack, Whit	
5-0036	1	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√ No	Specify:		Specify: Wh	ite
5-6	a la	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of works	16	6b. Kind of Business	/Industry
2121	P P P	m	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired	1)			
7 7	lygie nt. m		17. Father's Name (First, Middle, Last)		Cash	ier	18. Mother's Name	(First Middle Mr	Store	
anc	ed o	Be c	Fenton Palmer						,	
Maryland	mark mark	မ	19a. Informant's Name/Relationship (Type	oe. Print)	19b. Mailie	ng Address (Street		Marie T	City or Town, State, .	Zin Codel
Na	Ith ar 27 is r trau		Ann Marie Ferguson						ick, MD 21	
ē,	item othe	-	20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or	
OE S	nt: #		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-		ory 11/28	2/05 1	I a a a wat a	Mo
Baltimore,	Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netur any injury or other traumatic event. The Medical ODCs.		21. Signature of Fundral Service License	99 / 4//	/ lagerseo	2. Name and Addre	ss of Facility. Inhr	, т. Will	lagerstown iams Fune	ral Home
m a	Depe impo any i		Damaya VT	Wille	ac			swick, M		Tur Home
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused le cause on each lin	the death. Do not ent	ter the mode of dyin	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition		Dia	lie to	8 MG	Wite	us	Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as	a consequence of):		- / /			
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760,	ysicien e burial	cai		l						
Records, P.O. Box 687	ettending phys	Physician/Medi	IF FEMALE:							
Box	tendii or use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth		Ectopic pregnancy	,		23d. Date of de	
O. E	the et hed fo	sici	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)			Month	Day Year
Q. \$	ed by the e	Ph)	Part II. Other significant conditions con	stributing to death hi	ut not resulting in the u	inderiving cause giv	en in Part I	23e Did toha	icon use contribute to	the cause of death?
of Vital Records,	signe d be	d by					311 ATT 21(1.			robably 4 Dinknown
Sor	been si	Completed						24a. Was an	24h 18/050 S	utonou findings qualible
Re	s certificate hes b	m						autopsy performe	prior to death?	utopsy findings available completion of cause of
		ပိ	25. Was case referred to medical	777		-	26. Place of Death	1 Yes 2		2 □ No
of Vita	is cer	To B	examiner?	lospital:	nt 2 ER/Outpatie	nt 3 DOA Oth	-	-	ice 6 Other (Spe	city)
0 8	h. After this funeral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur	y 28b. Time o	f 28c. Injur Wor		28d. Describe how		
Sio	eath. or: Al	atic	2 Accident investigation				Yes 2 □No			
Division	after death. Director: A	i i	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	erai Derai	ပိ	29a Certifier 1 Certifying Phys	1000 - 1000 - 1000	a-congress menastros a mo	24,70002,000,000	NOT SERVICE VOICE OF	NAME OF THE PARTY.	CONTRACTOR OF THE SECOND	
Division	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification;	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	at my knewledge, dant examination and/or in ited.	vestigation, in my o	pinion, death occurr	ed at the time, dat	e and place, and du	e to the cause(s)
2	vithin Fo th	₩.	29b. Signature and little of certifier			29c. Licens	e number	290	d. Date signed (Mont	h, Day, Year)
•	, · · · ·		> Value		MO	1	5839	1	11.20	205
	2		30. Name and andress of pers woo co	mpleted cause of d	eath (Item 23a) (Type,	Print)		1		1
	J		SAJJAD A	212, M.	0. 801	Toll	House 1	the F	rederie	l, MD 21-70
	Sta		31. Date filed (Month, Day, Year)		ar's Signature			1		,
DUM	Regist		NOV 2 9	2005	ever St.	aporte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19a per th 8851 1-10-06 vt.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 26, Cynthia G. Finke1 November 2005 4:53A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. JAN - 7 , 1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 104-30-6218 65 New York Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-f show the Medical Examinal must be notified at 10a. State 1X Yes 2 □ No Maryland Rockville Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14223 Woodcrest Drive 20853 United States of America Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the eny Injury or other traumetic event, the once. Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Apelsin Goldie Gottlieb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Allan Finkel - Son **Husband**</u> 14223 Woodcrest Drive, Rockville, MD 20853
se of Disposition (Name of Date 20c. Location - City or Town 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State New Montifiore Cem. 11/29/05 4 □ Donation 5 □ Other (Specify) West Babylon, NY 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. 1 Re 1091 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 412DIA C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 250217 the attending physician and Due to (or as a consequence of) Box 68760, Medical Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown for hemachromatusil 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificate tes Abo 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Danpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A D 2331 26 2005 November 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) troderick RUAD Suite 213 GATHERSbury MD OSEPH BALL 16220 MA 32 Aegistrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

07

2005

DEC

ADH UNKNO 05-79	WN	[LL	IAM FINZEL, SR. Please Amend item	Type or Print in	Black Inde	lible Ink. Ensure	All Copies A	re Legible.	
05-19	7)3		For Unpend Item	State of Maryla 23a,27,28a-f	nd / Departi per me r G	lible Ink. Ensure ment of Health and 850 12-13-05 t	Mental Hygie as	ne 2005	1.0012
			Registrar 1. Decedent's Name (First, Middle, Lateral			icate of Death	2. Date of Death		3. Time of Death
	Physici /Medi		John William	Joseph	FIAZEL	SF.	NOVEMBER	25, 2005	0933 A M
6	Examir	er	4a. Facility Name (If not institution, giv. 13000 ST. GEORGE			o. City, Town, or Location of Dea MOUNT SAVAGE	ath	4c. County of Death ALLEGANY	
Q	Funeral		Social Security Number 6. S	ex 7. Age (In yrs	. last birthday) If	Under 1 Year If Under 24 Hr		9. Birthi	place (State or Foreign
9	Director		214-12-3380	ØM 2□F 85	Yrs.	onths Days Hours Mir		(Cou	MD MD
	yland sow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location	on		•	10d. Inside City Limits
	Ba-f et	Director	MD Allegan	ny M	lount	Savage			1 ☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Items 23e or 28e-1 show with jujury or other traumatic event, the Maulteal Examinat must be notified at ODGE.	Dire	13000 St. G			Of. Zip Code	10g	Citizen of What Coul	ntry?
	deeth ms 23	Funeral	13000 St. G	12. Was Decedent Ever in I		Z1545 Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	
36	or its		1 Never Married 2 Married	Armed Forces? 1		s, specify Cuban, Mexican, Pue Yes 2⊠No <i>Specify:</i>	rto Rican, etc.)	Black, White,	etc.
Ş	hours tural',	ed by	3	Year or Dates:		's Usual Occupation	10	Specify: W	nite
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Maryland 21215-0036	id be fi	To Be	PATRICK E.	Finzel		18. Mother's Na	ame (First, Middle, Mai	den Sumame)	
ary	and Me	F	19a. Informant's Name/Relationship (19b. Mailing A	ddress (Street and Number or F		ity or Town, State, Zip	Code)
Σ,	and 2 lealth a m 27 I		John Finzel,	Jr Son	384	Hyndman R.		man Pl	1 15545
Jore	nt of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispositio cometery, cremato	ry or other place)		. Location - City or To	own, State
Baltimore,	mit. Parameter Programme injury		4 □ Donation 5 □ Other (Specification of Figure 1 Service Licer			905 Johnston	in Vinately	Johnstour	1 PA
ä	Depa Impo eny li		A Cen	M	Ita	rvey H. Zeigle	r Funeral 1	tome Hyn	dman PA
			23a. Part1. Inter the disease, or shock, or heart failure. List of	plications that caused the dea one cause on each line.	ath. Do not enter th	e mode of dying, such as cardia	ac or respiratory arrest		Approximate Interval Between Onset and Death
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x 68	certificate be exe Iding physicien a ise es the burial i	Med	IF FEMALE:						
Вох	eath c ettend for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of	al death 3 □Ect	opic pregnancy ner (specify)		23d. Date of delive Month	ery Day Year
P.O.	The law requires that the death sie hes been signed by the etter page 2 should be detached for u	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		ter (specify)			
	es tha igned be del	þ	Part II. Dther significant conditions of	ontributing to death but not re	sulting in the under	lying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
ord	w require been si should I	Completed					1 Tes	2 No 3 Prob	ably 4 Unknown
Rec	The law cete hes t page 2 s	mpi					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
ital	ician: The lav certificete hes ector, page 2	Be Co	25. Was case referred to medicat			26 Place of De	eath (Check only one)		2 No
Division of Vital Records,	S S F	To B	examiner? 1X Yes 2 □ No		BR/Outpatient 3	04	Home 5 Residenc	e 6 ∭Other (Specif	v) SCENE
ou	ding P h. After t funere	ion:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 11-25-05	28b. Time of Injury 9:12 A	28c. Injury at Work?	28d. Describe how		
Visio	Attending r death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I	nome, farm, street.		28f Location /Stree	house fir	I Pouto Number
Ö	rs afte	Cert	4 Homicide determined	Home	ify)		City or Town, S Lane, NW,	Mount Sava	ge Georges
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ YMedical Exam	inter: On the pasis of examin	owledge, death occation and/or investi	curred at the time, date and place gation, in my opinion, death occ	e and due to the cause	e(s) and manner as si	lated
_	To the within 2 To the complet	Mec	29b. Signature and fittle of certifier	and manner stated.		29c. License number		Date signed (Month,	
	> - 0		1 Charles	(1)		OCME		EMBER 26,	
			30 Name and address of person who	completed cause of death (Ite	m 23a) (Type, Prin))			
	Sta	te.	31. Date filed (Month Day, Year)	32. Refistrar's Sign	111 PET	NN STREET, BALT	IMORE, MAR	YLAND, 212	201
	Registr		31. Date filed (Month, Day, Year) 2	2005 32. Hardistrar's Sign	& do	W			

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			1 - State Registrar		0.	ato 01 .	viai y tai i		rtificat				ioritai i i	Reg. N	00	5 1	.0013
	Physici	an.	1. Decedent's Nar	ne (First, Midd	le, Last)								2. Date of D Month	eath Da	ay	Year	3. Time of Death
	/Medic			s O. Ga			-		1				Noun	ser	21	2005	10:53 PM
	Examir	er	4a. Facility Name	Hos P								n of Death	+4	40	c. County	of Death	
	Funeral		5. Social Security		6. Sex			last birthday)	If Unde	r 1 Year	If Und	er 24 Hrs.	8. Date of B	irth		9. Birthp	place (State or Foreign
	Director		217-16-4	345	1 5 M	2 🗆 F		32 Yrs.	Months	Days	Hours	Min.	Jan 10	19 19	23	Cour	MD
	pur *		Usual Residence 10a. State	of Decedent 10b. County	,		10c. City	y, Town or Lo	ncation							1	0d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23s or 28s-f ehow or other traumatic event, the Medical Examinar must be notilized at	lor	MD		rroll				minst	er							1 ☐ Yes 2 ☐ No
	r 28a	irect	10e. Street and N	umber					10f. Zij	p Code				10g. C	itizen of \	What Cour	ntry?
	th with	ai D	1020 St	one Roa	ıd					21	158				USA	Δ	
	r dea	Funeral Director	11. Marital Status		_ A	med Force			Was Dece If Yes, spe	edent of H	ispanic (in, Mexic	Origin? (Sp. an, Puerto	ecify Yes or N Rican, etc.)	lo-		e Amend	can Indian, etc.
36	or h	by Fu		rried 2 ☐ Mar 4 ☐ Divorced	ried 1	Yes 2 Yes, Give ear or Date	⊒No WT	N 2	1 🗆 Yes	2 X No	Specia	fy:			Specify		ite
5-0036	2 hours	ed t	••	15. Deceder	nt's Education	n	J.	16a. Dece	dent's Usu	ial Occup	ation	-		16b. l	Kind of B	usiness/In	dustry
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nd	be fill d oth	Be	17. Father's Name		Last)								(First, Middl		n Suman	ne)	
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Z	and 2 sealth an n 27 is reference					11111)		12022	222	225							(Code)
ē,	s 1 and f Health item 27 other tr		Neal Ga 20a. Method of Di	isposition				lace of Dispo	Ston sition (Na	me of			unster Date			.158 City or To	own, State
Ë	Pages nent of h ant: if ite ary or of			2 □ Cremation □ 5 □ Other (5		val from Sta	ie i	keview	-		, ,	11/2	6/2005	Sy	kesv	ille	, MD
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of F	uneral Service	Licensee	/		P	Name a	nd Addres	ss of Fac	Home	and C	hape	1. P	.A.	
	205 = 9		pe	m V	1	0		4	12 Wa	shin	gtor	Road	L_West	mins			21157
				eart failure. List	r complicatio t only one ca	ns that caus use on eacl	sed the death n line.	n. Do not ent	ter the mod	de of dyin	g, such a	as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condit resulting in death	ion	a	Int	ra cr		he	Mer	had	e e					Iday
-	Examiner		, and the second			Due to (or	as a consequ	uence of):			1	4					
		Jer	Sequentially list of if any, leading to cause. Enter Und	onditions, immediate	b	Due to (or	as a consequ	uence of):									Years
	executed n and ial-transit	Examiner	that initiated even	or injury	S c.	Atri	e f.	brile	4:00					years			
, 0			resulting in death) Last		Due to (or	as a consequ	uence of):									
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	s tha		Part II. Other sign	nificant conditi	ons contribu	ting to deat	n but not resi	ulting in the u	nderlying (cause give	en in Par	t I.	23e. Did	tobacco	use cont	nbute to th	ne cause of death?
ord	equire ien siç ould b	ted	Insul	in de	pende	nt d	iabe	125	Mel	Litu	<u>s</u>		1	Yes 2	No	3 Prob	ably 4 Unknown
of Vital Records,	law r	Completed by	Conge	stive	heo	int	fail	une					24a. Wa aut	opsy		prior to cor	psy findings available inpletion of cause of
al H			3										1 Yes	formed? 2 X N		death?	2 X No
Vit	rsician: The law s certificate has b lirector, page 2 s	Be	25. Was case reference examiner?		Hospi	tal: , 🛁 .		500		OA Dth			(Check only				
o	g Phy er this	n: To	27. Manner of De	ath		Ba. Date of I	njury	ER/Outpatier 28b. Time o		UA	40		me 5 Res 28d. Describe				y)
Division	nding ath. r: Afte e fun	Table Tabl															
<u>×</u>	l or Attendi after death. Director: A I in by the fu	tific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ		Be. Place of building.	Injury - At ho	ome, farm, str	eet, factor	y, office			28f. Location City or To			er or Rura	l Route Number,
0	itai o Irs aft ral Di	Cer															
	Hosp 24 hou Fune fely fi	lical	29a. Certifier (Check only one)	1 Certifyii 2 Medical	Examiner:	On the basis	of examina	wledge, deat tion and/or in	h occurred vestigation	at the time, in my o	ne, date pinion, d	and place, eath occurr	and due to the ed at the time	e cause(s , date an	s) and ma id place,	nner as st and due to	ated. the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Mec	29b. Signature an			and manner	siated.			c. License							Day, Year)
			Na	staran	Rat	i el	MD			RE	S - C	000					, 2005
	10%		30. Name and ad					1 23а) (Туре,	Print)	_				-	- 0		, ~ ~ ~ ~
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	Sta		31. Date filed (Mo			32. Reg	trar's Signa	ture	1								
1	Registr	ar		NUV 2	3 200	3 12	Reser	K.	GOOD OF	es.							

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		For State Registrar	State of Marylar		partment of F ertificate of		•	giene Reg. No.	05	40014
Physicia /Medica		1. Decedent's Name (First, Middle, Las John Thomas G	'				2. Date of De Month	Day	Yeer 19 2005	3. Time of Death
Examine Funeral Director	er	4a. Facility Name (If not institution, give PALT, MDRE MASHEN) 5. Social Security Number 6. S 213-32-4549	GTON MRDIEAL			BURN If Under 24	1£	AK	•	Pur DEC place (State or Foreigntry) MD
g		Usual Residence of Decedent 10a. State 10b. County MD Anne An		ity, Town or		na Park	May 17	, 193		10d. Inside City Limit
death with the Maryland ms 23e or 28e-1 show rmant to rediffed at	Funeral Director	10e. Street and Number 138 Truckhouse I			10f. Zip Code	21146		10g. Citize	n of What Cour	1 ☐ Yes 2 💆 No ntry?
urs after	۾	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 19	953- 957	3. Was Decedent of Hif Yes, specify Cub		? (Specify Yes or No uerto Rican, etc.)		. Race - Americ Black, White,	
Z IZ IS-UUSO ad within 72 hours afi giene. er than "natural; or If a Medical Even.	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12	completed) College (1-4or 5+)	(Gi	cedent's Usual Occup ve kind of work done o. DO NOT use retire r Treatmer	during most of d)			of Business/In	
INTERVIEUG Z 1 Z 1 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	To Be (17. Father's Name (First, Middle, Last) Thomas Henderson	n Gatton			Albert	Name (First, Middle	enwell		
e, Mal 1 and 2 sh Health and lem 27 is n other traun		19a. Informant's Name/Relationship (Ellen Marie Gati 20a. Method of Disposition	ton/Wife	138	tiling Address (Street Truckhous position (Name of	se Road,	, Severna	Park,		1146
LIMO Timent of the standard of		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Company)	Removal from State G1	cemetery, c .en Ha	rematory or other pla ven Cemete	ery	ov. 23, 2005	Gler	Burnie	e, MD
Depariment of the permit of th		23a. Part1. Enter the disease, or com			Barrancode 495 Gov. I	Ritchie	Hwy, Seve	erna F	Park Fur Park, M	D 21146 Approximate
PA/OU, cate be executed /Medical Examiner the burial-transit	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect. d.	quence of): quence of):	suess					Interval Between Onset and Death
	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	B⊟Ectopic pregnanc; □ Other (specify)	y		230	d. Date of delive	ery Day Year
requires that the de seen signed by the a	ed by Ph	Part II. Other significant conditions o	ontributing to death but not re	sulting in the	underlying cause giv	en in Part I.		obacco use Yes 2 1		ne cause of death?
sician: The law requires t certificate has been signe irector, page 2 should be c							1 ☐ Yes	2 No	death?	psy findings available mpletion of cause of 2 No
Physician: This certificate ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpat	ient 3□ DOA Oth	200	Death (Check only only only only only only only only		Other (Secsif	···
Attending Physics of the funeral di	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injur	of 28c. Injur	v at	28d. Describe			7/
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	ity)			City or Tou	vn, State)		l Route Number,
Hosp 24 hou Fune stely fil	edicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exan	ysician: To the best of my kn niner: On the basis of examin and manner stated.	iowledge, de ation and/or	ath occurred at the tir investigation, in my o	me, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) an date and pl	nd manner as st ace, and due to	tated. the cause(s)
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Med	29b. Signature for little of certifier		10	29c. Licens				signed (Month,	* * * * * * * * * * * * * * * * * * * *
		CNARATO		Dital	e, Print)	Cites	Busne	e n	102	1061
Stat	е	31. Date filed (Month, Day, Year)	32. Sigistrar's Sign	ature	1 -					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 2 Date of Death 1. Decedent's Name (First, Middle, Last) NOV. 2005° **Physician** 23 8:05 P M FRANCIS CARROLL GOLEBIESKI /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**M 2□F Yrs. MAR. 22,1923 MARYLAND 216-12-9398 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2X No STEVENSVILLE **CUEEN ANNES** MD Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö 21666 822 MONROE MANOR USA or Items 23a Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1943-1946 1 ☐ Yes 2 X No Specify: δ WHITE 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than SHIPPING LONG SHOREMAN -0permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other th any injury or other traumatic event. the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HELEN PLACHER STANLEY GOLEBIESKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER-822 MONROE MANOR, STEVENSVILLE, MD 21666 STEPHANIE GOLEBIESKI/ IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State MD. VETERANS CEMETERY 11-29-2005 HURLOCK, MD *4 Donation 5 Other (Specify) 21. Signal of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Witens and Due to (as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part I). Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No has 1 Yes 2DNo Division of Vital : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation To the treesalter death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide ECcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier of person who/completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra 's Signature State 2005 Registrar

ORIGINAL

			For State Registrar	State of Maryland / D	epartment of Health ar		giene eg. Nó.: 005	40016
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	ROBERT 4a. Facility Name (If not institution, give s.	STREETT	GLADDEN JR. 4b. City, Town, or Location of	De C .	7, 2005 4c. County of Death	8:54 P ^M
	Examin	er	Baltimore Washi	001100	Glen Bu:		Anne Arun	del
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth				ce (State or Foreign
В	Director		210-22-3300	M 2□F 78 Y	rs. Northis Bays Tiodis	2/21/	1927 Mar	yland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10c	d. Inside City Limits
	Mary I sho	tor	MD. Anne Aru	ındel	Severna	Park		1 ☐ Yes 2 No
	th the or 28e e noti	lirec	10e. Street and Number		10f. Zip Code	1	10g. Citizen of What Country	y?
	ath wi	ral	102 Sycamore F		21146		United St	
	ltems rer	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces?1 XYes 2 □ No	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	in? (Specify Yes of No- Puerto Rican, etc.)	14. Race - American Black, White, etc	
936	urs aff		3 Widowed 4 □ Divorced	If Yes, Give WW II	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I thatth and Mental Hygiene. I tem 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, II is Maryland Examinar must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade	completed)	Decedent's Usual Occupation (Give kind of work done during most	of working	16b. Kind of Business/Indu	stry
2	within ene. than	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		M - 2012 P - 0 +11	
22	e filed within al Hygiene. other than vent, ine M.		1.2 17. Father's Name (First, Middle, Last)	2 Me	chanical Engi	neer 's Name (First, Middle, .	Manufactu Maiden Sumame)	ring
lan	lid be lental rked o	To Be	Robert Stre	ett Gladden	Sr. Mar	garet	Emmer	ich
ary	should be and Menta s marked umatic ev		19a. Informant's Name/Relationship (Type	oe, Print) 19b.	Mailing Address (Street and Number		r, City or Town, State, Zip C	⁽²⁾ 21113
	1 and 2 Health a tem 27 Is		Gary M. Gladde		64 Streamview		Odenton, M	
ore	o O		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	emoval from State cemeters	Disposition (Name of r, crematory or other place)		20c. Location - City or Town	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		' 4 □ Donation 5 □ Other (Specify)	The state of the s	11 Cremation			
Bal	permit. I Departm Importer any inju		21. Signature of Funeral Service License	King III	22. Name and Address of Facility E.G. Kurtz			
			23a. Part1. Enter the disease, or complia	cations that caused the death. Do n			rest.	Approximate Interval Between
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	1 =	ac arrest			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of	f):			
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7	. sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as a consequence o	r):			
v -	at-train	xar	that initiated events cresulting in death) Last	Due to (or as a consequence of	f):			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		d	l				
9	rtificat ng phy as th	Physician/Medical	IF FEMALE:			-		
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery Month D	y Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			
P.O.	res that the de signed by the a be detached i		Part II. Other significant conditions con	•	the underlying cause given in Part I.	23e. Did to	bacco use contribute to the	cause of death?
rds	quires n sign uld be	ed by	Prostute	cancer		1 🗆 Y	res 2 □No 3 □ Probab	bly 4 □Unknown
000	aw requir as been si 2 should	Completed				24a. Was a	an 24b. Were autops	sy findings available pletion of cause of
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of \	S 5	2	1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death	lospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T			ence 6 Other (Specify) ow injury occurred	
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	the h	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Month, Da	lav. Year)
L	T wit				12005138			
	20		30. Name and address of person who co	empleted cause of death (Item 23a) (Type, Print)		olis, MO 21.	5-6
			Kenn B Kroft		Type, Print) Sty4te RJ #38	Do Annapa	3 15 MD 21	49
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	-1-0-	b	-	
	Regist	rar	MEAT ON	with Bar 1/2	Langue V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Bety Jane Hughes

4a. Facility Name (If not institution, give street and number) Movember 25, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Jan. 19, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 21 F Year) 80 Yrs 376-20-8833 Jan. **1925** Michigan Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 ehow mary injury or other traumatic event, Its Mariling Exercities in control to confine the multified and once. 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14603 Edelmar Drive 20906-1762 U.S.A. Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiene. other then "natural", or item Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Auto Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Lutz Ella Augusta Fach 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Hughes / husband 14603 Edelmar Dr., Silver Spring, Maryland 20906-1762 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Nov. 26, 2005 Alexandria, Virginia Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Ligensee 500 University Blvd., W., Silver Spring MD 20901 au Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear failure. List only one cause on each line. Immediate Cause (Final Paronen la **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jarying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No thours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral (Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39793 Clinton Jay M.D. November 26, 2005

State Registrar

10

NOV 28 2005 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher J. Mays, MD 18111 Prince Philip

32 Registrar's Signature

ORIGINAL

Dive Otney

ms

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 23, 2005 **Physician** Paul G. Hausler 10:52 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick 6914 N. Clifton Rd. Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□ F Hours Yrs. 86 1918 Maryland Director 214-16**-**1067 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Frederick Frederick Completed by Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6914 N. Clifton Rd. 21702 Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Researcher U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hausler Gotlieb Wickles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Frederick, Maryland 21702 Pauline Hausler / Wife 6914 N. Clifton other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If its any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State St. John's Cem. 11/28/2005 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD Approximate Interval Between Onset and Death 23a. Pant other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. ryest, use Immediate Cause (Final Physician 1mm disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, farry, leading to init ediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 □Unknown 1 Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate urkinson Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending fter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours To the Funeral D 2 riffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 009689 parra Ö X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 300 W. Ninth St. / Frederick, Maryland Pearre 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) 2005 Registrar

		1 - For Amend#5 Per FH State Registrar 12/2/05 AACO			artment of H		Mental Hygie	ene	1.0020
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Examin		4a. Facility Name (If not institution, g Anne Arundel M		nter	4b. City, Town, o		th	4c. County of Deat	h
Funeral Director		215 24 8195 _{1 98}	Sex 7. Age 1 1 M 2 1 F	(In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Y		hplace (State or Foreign untry) ryland
Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	1	10c. City, Town or Lo					10d. Inside City Limits 1X Yes 2 ☐ No
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Medical Examiner hysician and the burial-transit	i Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Either Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	by one cause on each line A	consequence of):	myel	em,		,	Approximate Interval Between Onset and Death
Geath certific death certific	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
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		_	For State	State of	of Marylan	•	artment of H		d Mental Hy	giene Reg. No.	05	Lnn21
			Registrar 1. Decedent's Name (First, Middle, La	st)				504.7	2. Date of De	ath		3. Time of Death
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)	/Medic Examin	er	4a. Facility Name (If not institution, giv			14	4b. City, Town, or	Location of De	eath	4c. Cou	nty of Death	ies
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	the I	Medical	one) 29b. Signature and title of certifier		nner stated.		29c. Licens			29d. Date sig		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician November 21 2005 Berna Dean Holland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

Months Days Hours Min. May 5, 1926 Peninsula Regional Medical Center Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Months Director Maryland 215-20-0900 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland page parment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or the new nitry or other treumatic even. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Salisbury Maryland Wicomico Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 27370 Pemberton Drive by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medical 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pearl Bedsworth Luther Stephens ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 Pine Bluff Rd. Salisbury, MD 21801 Phyllis Oldham/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometen, crematory or other place Springhill Memory Gardens 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 25, 2005 Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A. 11 Kerth keeres 501 Snowhill Rd. Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner LUNG LANCER WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physiclen and for use as the burial-transit law requires that the deeth certificate be executed METASTASES Bn-a. $\sim m$ Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate hes l director, page 2 s autopsy performed? 2 No 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours efter To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Polit all Mis 029168 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1346 57. 21804 5 -DIVISION SAVISBUR MO 31. Date filed (Month, Day, Year) NOV 2 8 2005 32. Pegistrar's Signature State Registrar

			For State Registrer		ryland / De	epartme	ent of Health and Nate of Death	lental Hygie	_	40023
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death
	Physici /Medio		DONALD LEE HARRIS)				Month //	Day Year	1739 M
Ĭ.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Ci	y, Town, or Location of Death		4c. County of Death	1 ,
			PENINSULA REGION	Val Medh	an Can		ALISBUM		Hican	nico
	Funeral		Social Security Number 6. S	ex 7. Age ☐M 2☐F	(In yrs. last birtho	Month	der 1 Year If Under 24 Ars. s Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth Cor	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	Alw SUF	58 Yrs	S.		04-26-19	47 SALI	SBURY, MD.
	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow ledical Examinat must be notitled at	Į.	10a. State 10b. County MD WICON	(TCO	10c. City, Town o					10d. Inside City Limits 1 X Yes 2 No
	the 28a	Funeral Director	10e. Street and Number	1200	0112202		Zip Code	100	. Citizen of What Cou	untry?
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	death	Jera	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
9	after or Its		1 ☐ Never Married 2 ☐ Married	Armed Forces?	0		pecify Cuban, Mexican, Puerto 2 🗓 No Specify:	Hican, etc.)	Black, White	
8	ral', c	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 LI Yes	2LANO Specify:		Specify: W	HITE
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2		ပိ	12	3	ELEC	LKICA	L ENGINEER			ANI
Maryland 21215-0036	e d ii b	Be	17. Father's Name (First, Middle, Last) BENJAMIN F. HARR				DOROTHY	e (First, Middle, Ma M. HOOK	iden Sumame)	
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<u>a</u>	~ ~ ~		19a. Informant's Name/Relationship (-	ess (Street and Number or Rur GO TERRACE, SA			
	s 1 and 2 f Health Item 27		BARBARA A. HARRIS	s - SPOUSE	20b. Place of D		at the state of the latest and the state of	-	c. Location - City or 1	
ŏ	o 0		1 to Burial 2 □ Cremation 3 □		cemetery,	crematory o	r other place)			
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Baltimore,	permit. Departm Importe any inju		21. Signature of Fundami Service Licen	see herren			and Address of Facility BO			
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			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only							Interval Between Onset and Death
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				CARDIOUGEL	Hae DIS	ease	
	Examiner		ſ	Due to (or as a	consequence of):					
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m	atten for u	clai	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐Ectopic 5 ☐ Other			Month	Day Year
P.0.	at the de by the a tached	hys	9 ☐ Unknown	9□ Unknown						
	\$ 00 B	by P	Part II. Other significant conditions of	ontributing to death bu	it not resulting in th	ne underlyin	g cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	an sign							1 ☐ Yes	2 ☑ No 3 ☐ Pro	bably 4 Unknown
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ta		0	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2 ₽ h Check only one	SNO TO THE	2□ No
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io	nding I ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Ye <i>ar)</i> Inju	M M	Work? 1 ☐ Yes 2 ☐ No			
Division	or Attending efter death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Inju	ry - At home, farm	, street, fact	ory, office		et and Number or Ru	ral Route Number,
ā	al or Att s efter de al Direct ed in by t	Seri	4 I Homedo	building, etc	. (Зреспу)			City or Town,	orare)	
	e Hospital of 24 hours el etely filled i	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	nysicien: To the best of niner: On the basis of and manner state	examination and/o	leath occurr or investigati	ed at the time, date and place, on, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. License number	29d	. Date signed (Month	, Day, Year)
	3		Vaul R Il	my MO			024872		1/28/05	-
	3		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tu				. , , ,	
	12		30. Name and address of person who PAUL FLEUR	YND	305 7	enth	ST Pocom	oke City	MD 218	7/
	Sta	ite	31. Date filed (Month, Day Year)	32. Registra	r's Signature					
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			1 - For State Registrar	State of Ma	arylan				ealth and I Death	-	giene	005	40026	
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	Examir Funeral Director		4a. Facility Name (If not institution, give Coastal Hoss. 5. Social Security Number 6. \$ 217-36-0194	oise at	the o (In yrs.	Lake last birthday) Yrs.	So	lisk or 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JUNE 19	th y, Year)	County of Death	n i CO nplace (State or Foreign untry) RYLAND	
	aryland ehow dat	_	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation			·			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	ith the Marylar or 28a-1 ehow	Funeral Director	MD WICON	4ICO	SA	LISBUR		p Code			10g. Citi	izen of What Co		_
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036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinal must be incitified at	þ	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	Ever in U No			edent of Hecify Cuba 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race · Amer Black, White Specify: WH		
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	e Hospita 24 hours e Funera	edical (29a. Certifier Coneck only one) Certifying Ph	ysician: To the best niner: On the basis of and manner sta	examina	wiedge, death ition and/or in	occurre vestigation	d at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)	
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ars signa	M. A	house	P)′		

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	/Medic	al	Christine Jo 4a. Facility Name (If not institution, give :			4h City 1	Town or	Location of		Novemb		20 200 County of Dea		ĎΜ
	Examin	er	Future Care	,			101d		or Bouth			ne Arı		
	Funeral		Social Security Number 6. Sex	27_		If Under		If Under Hours	Min	8. Date of Bir	rth	9. Bi	rthplace (State or	Foreign
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	yland now		10a. State 10b. County	10c. City, To	own or Lo	cation							10d. Inside City	
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ore,			20a. Method of Disposition	20h Place	of Dieno	eition /Nam	a of	1	Dr	ato.	00- 1	Other	Taura Chata	
Baltimore,	Pages ment of I ant: If its ury or o		[‡] ☐Burial 2 ☐ Cremation 3 ☐ R • 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Eben Ceme	ezer	r AME	Ch	urch	Nov	.28 2	005	Gales	ville,	Md.
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	To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Cartifying Physical Examination 2 Madical Examination	sician: To the best of my knowled nar: On the basis of examination and manner stated.	ge, death and/or in	occurred a	it the time	e, date and inion, deat	d place, ar	nd due to the	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
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				Us.	M		0	50	72	5	11-	21-	200	5
			30. Name and address of person who co	mpleted cause of death (item 23a) (Type,	Print)								
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			1 - For State Registrar	State of Ma	aryland /			of Health of Deat			ene 0 0	5	40026
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	Physici /Medic		Audrey Jean Jon							Nov	19	2005	12:33 A M
	Examin	er	4a. Facility Name (If not institution, gi 28068 Beddington					own, or Location	n of Death		4c. County		
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	Funeral Director		214–66–8915	1 M 2 □ ¥F	49	Yrs.		Days Hour		8. Date of Birth (Month, Day,	Year)	Cour	
			Usual Residence of Decedent		42					Mar 24,	1956		MD
	yland		10a. State 10b. County		10c. City, To	wn or Loc	ation					1	0d. Inside City Limits
	a-fal	cto	MD Wicomi	co	Sali	.sbur	У						1 ☐ Yes 2 🔀 No
	or 28	Oire	10e. Street and Number				10f. Zip C			10	g. Citizen of V	What Cour	itry?
	ath w	Funeral Director	28068 Beddington	T				801			USA		
	ltems	nue	11. Marital Status	12. Was Decedent I		13. W	as Decede Yes, specif	nt of Hispanic y Cuban, Mexi	Origin? (Spe can, Puerto I	cify Yes or No- Rican, etc.)		e - Americ ck, White,	
5	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	NO	1	☐ Yes 2	₩ No Spec	ify:		Specify	Bl	ack
215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show than Madical Examinat must be notified at		15. Decedent's E	ducation	16	ia. Deced	ent's Usual	Occupation		1	6b. Kind of Bu	usiness/Inc	dustry
2	hin 7	Completed	(Specify only highest g. Elementary/Secondary (0-12)	rade com <i>pleted)</i> College (1-4or 5	5+)	life. D	O NOT use	done during m retired)	iost of workir	ng			
7	or thu	Con		5			Tea	acher					ucation
and	d oth	Be	17. Father's Name (First, Middle, Las					18. Mo	ther's Name	(First, Middle, N	aiden Suman	10)	
<u>Z</u>	Men	၉	Marion Johnson,						arl Jo				
Mar	12 sh h and 7 Is rr traurr		19a. Informant's Name/Relationship		1					l Route Number,	-		Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at an once.		Rhonda Jones/dau	ghter	20b. Place	of Dispos	ition (Name	of	Way. S	alisbur	Oc. Location -	21801 City or To	wn State
2	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3		cemel	tery, crem	atory or oth	er place)				,	m, otato
saltimore	artme ortani injury	1	' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature on Funs at Japan Lice		st. c			C Cem Address of Fa		5/2005	Chance,	, MD	
n	permi Depa Impo any ir	J. J	LATA			L	ewis 1	N. Wats	on Fun	neral Ho	ne		
	7 7 7		23a. Part. Enter the disease, or con	nplications that caused	the death. Do	o not ente	r the mode	Of dying, such	Sall as cardiac o	sbury, I r respiratory arre	4D 2180 st,)7	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	rone cause on Each in		Pa	10.5		N/. L	estatio		1	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequenc	-	VICEN		DUCKE	15tatic			14VS 7mos
	Examiner		Sequentially list conditions	b									
Mr.	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	e of):							
	and and I-trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequenc	e of):							
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28		edical		_ d								i	
XOD	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Dat	e of delive	ry
Ď	death e atte	cla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pred Other (spec				Mo	nth	Day Year
5	at the by th tache	hys	9 □ Unknown	9□ Unknown							ļ		
Ś	w requires that the death certif been signed by the attending should be detached for use at	by P	Part II. Other significant conditions	contributing to death be	ut not resulting	in the un	derlying cau	ise given in Pa	rt I.	23e. Did tob	17		e cause of death?
פ	equir en si ould	ted								1 🗆 Yes	2 (X No	3 Prob	ably 4 Unknown
Hecord	law ras be	ompieted								24a. Was an autopsy	. p	prior to con	osy findings available npletion of cause of
	: The cate has page	Con								perform 1 Yes 2	ed? X No 1	death?	2 No
Vital	ding Physician: The lav h. After this certificate has funeral director, page 2:	Be	25. Was case referred to medical examiner?	Hospital:				Other		(Check only one			
=	Phys this ral dir	: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatie	ont 2 ER/0	Outpatient . Time of		4 🗆		ne 5 Resider 18d. Describe hov			")
5	ding h. After fune	tlon	1⊠Natural 5 ☐ Pending	(Month, Day		Injury	м	injury at Work? 1 ☐ Yes 2		od. Doscribe not	v injury occurr	90	
UNISION	Atten deal octor: by the	ertification;	3 Suicide 6 Could not	be 28e. Place of Inju	ury - At home,	farm, stre	et, factory,			8f. Location (Stre	et and Numb	er or Rura	Route Number,
\leq	al or Attending P s after death. It Director: After to id in by the funera	Certi	4 Homicide	building, etc	c. (Specify)					City or Town,	State)		
	ospita hours unera ly fille		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowled	ge, death	occurred at	the time, date	and place, a	nd due to the car	use(s) and ma	nner as st	ated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one)	miner: On the basis of and manner sta	ated.	and/or inv							
	To with	Σ	29b. Signature and title of certifier	160	. 1		29c.	License numbe		29	d. Date signed	d (Month, L	Day, Year)
	3		Mysl	Il XIII	iles	My)	D47	232		(1)	28/	2005
	Ch		30. Name and address of Jerson who									-0.4	
	Sta	10	Mary S. DeShie	1ds, MD 50	9 Idley ar's Signature	vild_	Avenu	e, East	on,Md	. 21601			
	Sta Registr		31. Date filed (Month, Pay Year)	2005	h	1 1	00 N.						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** CHARLES STANLEY KARMOSKY NOVEMBER 24, 2005 /Medical 5:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Director 62 223-52-6954 MAY 31,1943 VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 27 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND **QUEEN ANNES** STEVENSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 EARECKSON LANE death 21666 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is markad other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 ARCHITECT ARCHITECTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ CHARLES STANLEY KARMOSKY ELIZABETH MACENKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If itam 27 is 230 EARECKSON LANE STEVENSVILLE, MD 21666 CHRISTINE C. KARMOSKY (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. STEVENSVILLE CEMETERY 11/26/2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. CHESTER, MD 21619 106 SHAMROCK ROAD 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SMALL CELL LUNG CANCER 17 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 2 🗌 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one) examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hour. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ammo D0059173 NOVEMBER 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHLEEN A. KEMMER 900 BESTGATE ROAD SUITE 300 ANNAPOLIS, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		•	For State Registrar	State of	Maryland		artment of F		and Mental	Hygie Reg.	21111	5	100	28
			1. Decedent's Name (First, Middle, L	ast)					2. Date Mont	of Death	Day \	/ear	3. Time of	Death
	Physici /Medic		Victor Michael						Nove		27, 20	05	2:30	ам
	Examin	er	4a. Fecility Name (If not institution, g				4b. City, Town, o		of Death		4c. County of	Death		
			Montgomery Gene 5. Social Security Number 6.		Ltal . Age (In yrs. Ia	et hirthday)	Olr If Under 1 Year		24 Hrs. 8. Date	of Dirth	Montg			. Consiso
	Funeral Director		338-07-2893	¥□M 2□F	91	Yrs.	Months Days	Hours	Min. (Mon	th, Day, Ye			ace (State o	rroreign
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	how		10a. State 10b. County		10c. City	, Town or Lo	cation					10	Od. Inside Cit	
	Se-fs	cto	Maryland Montg	omery	В	rookev	ille						1 🗌 Yes	24 No
	ith th	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wh	at Coun	try?	
	ath v		19301 Richwood	-			20833				USA		1	
	d within 72 hours after death with the Maryland jiene. r than "natural", or Itema 23a or 28e-f show The Medical Exarch artranat be codified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced	es?	5. 13.	f Yes, specify Cub	an, Mexicar	gin? (Specify Yes n, Puerto Rican, et	or No- c.)	14. Race Black,	White,		
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rds, P	signed be de	þ	Part II. Other significant conditions	contributing to dea	ath but not resu	lting in the u	nderlying cause gr	ven in Part I	. 23e.		2 No 3			eath? Inknown
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of o	Physi this c	၉	1 Yes 2 No			R/Outpatier	JU DOA		rsing Home 5				')	
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<u></u>	Attending r death. ector: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	be 380 Blace	of Injury - At hor	me farm str	eet, factory, office	183 2		tion (Street	and Number	or Rura	Route Num	her
Division	or Attencation after death Director:	Certification:	4 Homicide determine	buildin	g, etc. (Specify)	eet, factory, office			or Town, S		0, 710,00	710510 745111	007,
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	-11		m. Bayol	Do M	1. D		DOC	252	49	11	1271	20		
•	>11		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	4			10	/ \	~		
-31			MAHETEME	BAYET	1, 731	O Rivi	lera St.	Templ	e Hills,	MD 2	0748_			
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Registrar DHMH 17 Rev 1/2001

State

32 Registrar's Signature

David W. Hirshfield, M. D.

2005

07

31. Date filed (Month, Day, Year)

		_	For Stete Registrar		f Maryland / D	epartment of I Certificate of		Reg	ene 05	40030
	Physici		1. Decedent's Name (First, Midd Lotte Meyer	ile, Last)				2. Date of Death November	Ž1, 200	3. Time of Death 7:00 А м
	/Medic Examin		4a. Facility Name (If not institution	on, give street and nu	mber)	4b. City, Town,	or Location of Dea	th	4c. County of [Death
			Hebrew Home o						Montgo	
	Funeral Director		5. Social Security Number 522-54-7628	6. Sex 1 ☐ M 2X ☐ F	7. Age (In yrs. last birth	rs. If Under 1 Year Months Days			, 1908 ^{9.}	Birthplece (State or Foreign Country) Germany
	land ow		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town	or Location				10d. Inside City Limits
	Mary B-f sh	tor	Md Mont	gomery	Rockvi	11e				1 X Yes 2 □ No
	th the	Jrec	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	it Country?
	ath w	ral	6121 Montrose			2085			U. S. A	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumetic event. The Medical Evantics must be notified at the	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ▼ Widowed 4 □ Divorce	Armed Fo	2 X No ve	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 【X No		to Rican, etc.)		American Indian, White, etc. Vhite
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Maryland	d be fill antal H ted oth	Be c	17. Father's Name (First, Middle Robert Weil	e, Last)				me (First, Middle, Ma L (Unknown	_	
ary.	should nd Me mark umarti	2	19a. Informant's Name/Relation	nship (Type, Print)	19b.	Mailing Address (Stree				ite, Zip Code)
Ž,	and 2 alth a 27 is er tra		Thomas C. Mey	ver - Son	54	24 Whitley	Park Ter	race, Bet	hesda, M	Maryland 20814
Baltimore,	Pages 1: nent of He nt: If iten rry or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 1 ☐ Donation 5 ☐ Other (3 🙀Removal from	State cemetery	Disposition (Name of r, crematory or other plant Dunt Cremat			oc. Location - Cit	
Balti	permit. Departri		21. Signature of Funeral Service	2 Stran		22. Name and Addr Danzansky	ess of Facility -Goldberg	Memorial	Chapels	s, Inc.
		П	23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that o	caused the reath. Do no	ot enter the mode of dy	VIIIC P1k ing, such as cardia	c or respiratory arres	lle, Mar	Approximate Interval Between
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	death certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregnancy				23d. Date of	f delivery
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	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certify (Check only one) 1 Medica	al Examiner: On the b	e best of my knowledge, pasis of examination and oner stated.	death occurred at the t Vor investigation, in my	ime, date and plac opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manne e and place, and	er as stated. due to the cause(s)
	To the To the	Me	29b. Signature and title of certif			29c. Licen	se number			Month, Day, Year)
)	4		▶ 2mu	Jam	my	0	8084	1	JOVEM.	BER 21, 2005
	'		Name and address of person	Tho completed cau	se of death (Item 23a) (W-1) - 6/2	Type, Print) 1 MONTA	ese RI	Reck	/RLE, M	BER 21, 2005 10 20852
	Sta Registi		31. Date filed (Month, Day, Yea	7 2005	legistrar's Signature	Aparle	,	/		

LOTTE MEYER

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV. **Physician** 2005 6:31р м Ellen Moultrie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Chesapeake Arnold Anne Arundel 8. Date of Birth (Month, Day, Year) Feb. 28, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🔀 F Months Days Hours Min. 251-38-3086 77 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exercit or Investice Indiffed at MD Prince Georges Bowie 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11611 Silver Gate Lane 20723 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after of Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 8 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Chaplin Pickens Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8440 Pamela Way, Laurel, MD 20723 Lula Heatley/Daughter Health Item 27 I Date 25, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 2005 Department of H Important: If Ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul AME Cemetery Irmo, SC ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Priysician tnd stage monli disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an page 2 autopsy 2 1 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Seath (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Voursing Home 5 Residence 6 Other (Specify) P 2 NO 1 🗌 Yes this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 1 Tes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies Name and address of person with completed cause of death (Item 23a) (Type, Print) teransthwy M. Versvil 860 State Registrar

		1- State of Maryland / Dep	partment of Health and Nertificate of Death		2005 40032
Dhusia		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
Physic /Medi		Jeannette Lorraine Melvin		Nov.	25, 2005 1:15 P M
Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Funeral		17380 Gooden Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Marydel // If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	Caroline 9. Birthplace (State or Foreign
Director		219-36-5411 1 M 2XDF 64 Yrs.	Months Days Hours Min.	(Month, Day, Y	
D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	agation	110,10,10	10d, Inside City Limits
Aaryla f sho	ō				1 ☐ Yes 2X No
the h	Director	MD Caroline Maryde	10f. Zip Code	10g	. Citizen of What Country?
th with	ai D	17380 Gooden Road	21649	1	U.S.A.
ams ams	Funerai		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ▼No Specify:	, ,	Specify: White
21215-0U36 d within 72 hours af giene: ar then "natural", or the Madical Exam.	ed b	A	edent's Usual Occupation	16	b. Kind of Business/Industry
C I'm	piet	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ring	·
	Completed	11 Ma1.	Sorter		ail Processing
⊆ 9 = 0 ≥	Be	17. Father's Name (First, Middle, Last)	_	e (First, Middle, Ma.	
Ore, Maryland es 1 and 2 should be file of Health and Mental Hy fitem 27 la marked oth r other traumatic evant	2	Harry Seward 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	EIS1e ling Address (Street and Number or Run	Wheeler	Seward
C = 44 F		· ·	Greenbrier Rd; Har		
or Hear	100	20a. Mathod of Disposition 20b. Place of Disposition competery, or	position (Name of ematory or other place)	Date 20	c. Location - City or Town, State
Pages Pages nent of ant: If it		I Dutial 2 Defination 3 Definition 3(ate	111e Cemetery 11/30	0/2005 Ter	mpleville, MD
baltimore, parmit. Pages 1 ar Department of Hae Important: If item any injury or otha		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Gleegle and Helfenl O Box 100 Greens by	gein Fung	Home, PA
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death) a. (erebrova.5a)	ar Accident		Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
	ь	Sequentially list conditions, if any, leading to immediate bulle to (or as a consequence of):			
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
/bU, le be executed /sician and e burial-transit		resulting in death) Last Due to (or as a consequence of):			
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beath certificate eattending physic for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
death death e atte	iciai	in the past 12 months? 1 Dive Dirm 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
at the de tby the a	hys	9 Unknown			
- F 2 A	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	h /	cco use contribute to the cause of death?
ecords, law requires t as been signs	eted	Diaveres		Yes	2 No 3 Probably 4 Unknown
The law ate has boage 2 st	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
VITAL Ilcian: Ti	e Co	25. Was case referred to medical	GC Plane of Deat	1 Yes 2	No 1 ☐ Yes 2 ☐ No
	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Othory	h (Check only one) ome Residenc	e 6 □Other (Specify)
ng Pl	nc: T	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how	
Attanding Attanding r death. actor: After by the fune	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
in the second	Certification;	4 Homicide determined 289. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28t. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
urs urs aral		29a. Certifier 1 Operatifying Physician: To the best of my knowledge, dea	ith occurred at the time, date and place,	and due to the caus	se(s) and manner as stated.
To the Hosi within 24 ho To the Fund completely f	ledical	(Check only one) Modical Examiner: On the basis of examination and/or and manner stated.			
with To T	M	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		30. Name and address of person was completed cause of death (item 23a) (Typi	00 HOUS 687	3 1/10	overly 28 2005 a J. Karnes
		30. Name and address of person windcompleted cause of dealy (term 23) (type	00 Md. 21636	Patrici	o J Kaines
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		7 6 50-1	<u> </u>
Regist	rar	NOV 2 8 2005	parles		

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			For State Registrar	State of Marylan		artment of F		Re	g. No.	40034
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	
	/Medic		Patty C. Nich					Nov.	21, 200	
	Examin	ıer	4a. Facility Name (If not institution, give st			•	Location of Death		4c. County of De	
			203 Somerset Ba 5. Social Security Number 6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Year	Burnie If Under 24 Hrs.	8 Date of Birth		Arundel
	Funeral Director			M 2□F 77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 26	1928	lirthplace (State or Foreign Country) VA
	Maryland I show	tor	10a. State 10b. County Anne Ar		y, Town or Lo G	cation len Buri	nie			10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28a	Il Direc	10e. Street and Number 203 Somerset Bay D	rive, Apt 10	3	10f. Zip Code	061	10	g. Citizen of What	Country? JSA
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avant, It a Medical Exactional Let a difficulate.	by Funeral Director	-	2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No 195 If Yes, Give Year or Dates: 195	s. 13. y	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, W	merican Indian, nite, etc. Vhite
Maryland 21215-0036	hin 72 ho e. an "natur Medicul	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	OO NOT use retired	during most of work d)	sing 1	6b. Kind of Busines	
21	y with	Con	10			Boilerm	-		Local	193
/land	12 should be filed within h and Mental Hygiene. 7 Is marked othar than " traumatic avant, tha Me.	To Be	17. Father's Name (First, Middle, Last) Walter Nicholson					e (First, Middle, M beth Nic	_	
	1 and 2 sho Health and I tem 27 Is ma othar trauma		19a. Informant's Name/Relationship (Type Agnes O. Nicholson						City or Town, State 103, Glen	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item : any injury or othan once.		20a. Method of Disposition 1 ScBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, cren	sition (Name of natory or other place 11 Cemete	ery Nov	. 25.	Oc. Location - City of Brooklyn	
Balti	permit. Pages of Department of Himportant: If ite any injury or ot once.		21. Signally of Funda al Service Licenses	All	42	arrance 95 Gov R	& Soris, P	.A. Seve		Funeral Home
	Fnysician /Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.	neer	er the mode of dyin	ig, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
8760,	cate be executed obly sician and the burial-transit	ical Examiner	cause. Enter Underlying Causes (Lieuwe or Krieny that initiated events resulting in death) Last d.	Due to (or as a consequ	uence of):					
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of o	lelivery Day Year
Δ.	puires that n signed b uld be deta	by	Part II. Other significant conditions conti	ributing to death but not rest	ulting in the ur	nderlying cause giv	en in Part I.	-	_	to the cause of death? Probably 4 Unknown
al Records,		Completed						24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of s 2 \square
Vital	Physician: this certificaral director, a	Be	25. Was case referred to medical examiner?	spital:		- Oth		h (Check only one		
of	ding h. After fune	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe hov	ice 6 Other (Sp v injury occurred	ecity)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre			28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	To tha Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	cien: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dar	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier			29c. License			d. Date signed (Mo	
			30, Name and address of person who con	apleted cause of death (Item	1 23a) (Type.	Print)	52767		11/21/0	5
	CA-	ate.	HARMINDER J 31. Date filed (Month, Day, Year)	32. Figistrar's Signa	H 14	400 FER1	EST GLE	NRO H	+35 SIC	VERSPRING
	Sta Registi		NOV 23 20	32. Fligistrar's Signa	1 4	mode)		1 1 1 1 1	- 7 10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 5 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:22 AM Nichols Mathews 13 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dorchester 4448-2 Elwood Camp Road Hurlock If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 18 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 MM 2□F Months Days Yrs. 1941 Maryland Director 217-40-6541 64 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a, State or 28e-f show the Medical Examination past be notified at 1 ☐ Yes 2 No Director Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 4448-2 Elwood Camp Road 21643 permit. Pages 1 and 2 should be filed within 72 hours after death ' Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Wedical Exameter is ust Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) None None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eliza Thomas Moses Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Nichols (Cousin) 25343 Ocean Gateway Mardela, Md. 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 128/05 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem.Garden / Hebron, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home 821 West Rd.Salisbury,Md.21801 21. Signature of Funeral Service Licensee Hladys B, Stewar Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arrh m **Physician** Milline disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of). Examiner burial-transit that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of): Box 68760 signed by the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month detached for 4 ☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death Certification: To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After Natural Injury 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral I Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 16388

Registrar

State

MIC

31. Date filed (Month

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Collin

who completed cause of death (Item 23a) (Type, Print)

7 8 2005

MID

Registrar's Signature

			1 - State Registrar	State of Marylan		rtificate of L		iu Mentai Hy	giene Reg. No.	005	40036
			1. Decedent's Name (First, Middle, Las		2. Date of De		3. Time of [
	Physicia		JOHN LONZO O'NEIL			L	Novemb	er 20	20,2005 8:03 I		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of I			ounty of Death	
	LAGIIIII	CI	7403 Hillside	Drive		Frede	erick		F	rederio	.k
	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year	If Under 24		rth	9. Birth	place (State or Foreign
	Director		218-32-3971	MM 2□F 7	1 Yrs.	Months Days	Hours	DEC. 31	ay, Year) . 1933	Mary	ntry) \ Land
			Usual Residence of Decedent					12-0.01	,,,,,,,,		
vlanc	a how		10a. State 10b. County		y, Town or Lo						10d. Inside City Limits
Mar	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic avant, the Medical Examiner must be notified at once.	to	Maryland Frede	rick F	rederi	Lck					1 ☐ Yes 2 X No
the		Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?
, with			7403 Hillside	Drive		2170	02		Unit	ed Sta	ites
deat		Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin	? (Specify Yes or No	0- 14	1. Race - Ameri	
e de c	- 4	Ī	1 Never Married 2 Married	1 XYes 2 No		1 ☐ Yes 2 ☒ No	Specify:	dello ricali, etc.)		Black, White	etc.
S S	- 3	þ	3 Widowed 4 Divorced	Year or Dates: 1956-	-58	1 1 1 es 5 7 1 40	Spacity.		3	Specify: Wh	ite
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should be	Ment	2	John Donald O'Neill Ruth Bice								
Shoot	and		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number	or Rural Route Numb	er, City or	Town, State, Zi	Code)
end.	n 27		Carol J. O'Neill				Ct/Ap	t. 215 / F			
9 - C	t te		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		lace of Dispo emetery, cre	osition (Name of matory or other plac	:е)	Date	20c. Loca	ation - City or T	own, State
Pages	nent ant: I		4 □Donation 5 □ Other (Specify		sthave	n Mem.Gar	den 11	/28/2005	Fred	erick,M	aryland
Dermit	Departi Imports eny inj		21. Signature of Funeral Service Licen	1500	2	2. Name and Addres	ss of Facility	Stauffer	Funer	al Home	s, P.A.
3 8	88 3 28		Kaymon (Feleren	1	1621 Oposs	sumtown	n Pike/ Fr	ederi	ck, MD	21702
			23a. Part1. Enter the disease, or com- shock of heart failure. List only	plications that caused the deat	h. Do not en	ter the mode of dyin	g, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between
7	hysician		Immediate Cause (Final disease or condition	Shat	1/1.	Would to Hand					Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conseq	Due to (or as a consequence of):						
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5 8	attending pt	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete	ancy				0.5	d. Date of deliv	00/
deat C	e att	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Tectonic organizacy			23	d. Date of deliv	O1 y
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** tbraham 100 lember 28 2005 0154 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year Months Days If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 12 M 2 □ F Hours 010-18-4826 86 Director JULY 16, 1919 MA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits m 27 is marked other then "neturel", or items 23a or 28a-f shown treumstice event, the Modical Examinant must be notified at or 28a-f shov CANADA ONTARIO WINDSOR 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2870 BUTTERY COURT N9E3W4 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MECHANICAL ENGINEER **ENGINEERING** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H lant: If Item 27 ie marked ott Be LOUIS POLONSKY CECELIA LASSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY LEVINE/DAUGHTER 18 BIRCHWOOD CIRCLE, SHARON, MA 02067 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1

Burial 2 □ Cremation 3 □ Removal from State PLYMOUTH ROCK CEMTRY 4 Denation 5 ☐ Other (Specify) 11/30/2005 BROCKTON, MA Departr Departr 21. Signature of 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respiratory
Due to (or as a consequence of): **Physician** minutes /Medical Examiner years Fibrillation atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit ed by the attending physicien and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Yea 4 Pregnant at time of death 5 Other (specify) 9 Unknown this certificete has been signed by al director, page 2 should be detact Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No Attending Physicien: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 XNO 2 PR/Outpatient 3 □ DOA 1 ☐ Yes neral Director: After the filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lovember 28, 2005 herrier mo D 369 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com Deburah Sherr 9901 medical centeror. Rockville, mo 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 07 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	state of Marylan		artment of He rtificate of D			giene Reg. No:	NUC	400:	38
	Physicia	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of De.	Day	Year	3. Time of D	eath
	/Medic		ELMER			ARRET		MODEM	BEA	23 05	20=2	7 M
	Examin	er	4a. Facility Name (If not institution, give stre			4b. City, Town, or I				County of Dea		
	Funeral		HAR POND MEMO 5. Social Security Number 6. Sex	7. Age (In yrs.				GAACE S. 8. Date of Bird		1 A A C C		Foreign
	Director		214-26-2174 ¹₹M	^{2□} F 78	Yrs.	Months Days	Hours Mir	8. Date of Bird (Month, Da Nov. 17	y, Year) 19		rthplace (State or I country) aryland	or orgin
	D >		Usual Residence of Decedent 10a, State 10b, County	100 Cit	y, Town or Lo						,	
	Aaryla I ehov	ō	Maryland Cecil	100.00	y, TOWN OF LO						10d. Inside City	
	the N	Director	10e. Street and Number			10f, Zip Code	eposit		10a. Citi	zen of What C	ountry?	
	h with		9 Locust Lane			2	1904			U.S.	•	
	ems 2	Funerai	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cuban		Specify Yes or No	-	14. Race - Am Black, Whi	erican Indian,	
36	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Medical Evaluation in Item to molified at	by Fu	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	110 1100111 01011		Canaifu		
21215-0036	tural	ed b	15. Decedent's Educat	Year or Dates: 1950-		dent's Usual Occupat	tion			nd of Business	White	
215	hin 72	plet	(Specify only highest grade of	ompleted) College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	iring most of w	orking			al Center	r
	er the	Completed	Eight Years			Custodia	n				t, Maryla	
ind	be fill d oth	Be	17. Father's Name (First, Middle, Last)	D 66 0.			18. Mother's Na	ame (First, Middle,				
Maryland	hould d Mer marke matic	ပ္	19a. Informant's Name/Relationship (Type,	Parrett, Sr		ng Address (Street ar	ad Numbos os E			Laird	7:- O- d-1	
	od 2 s lith an 27 ls r treu		Juanita E. Parrett			cust Lane,					21904	
ře,	of Heal		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date		cation - City or		
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem `4 ☐ Donation 5 ☐ Other (Specify)	ioval itulii State		& Co., Inc		/25/05	West	Chester,	Pennsylva	nia
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Evant control to multiply at once.		21. Signature of Funeral Service Licensee	HERRY Z	Le	Name and Address ee A. Patt	erson 8				P.A.	
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the death	n. Do not ent	erryville, er the mode of dying	such as cardia	ac or respiratory ar	rest,	00	Approximate Interval Betwe	en
	Physician		Immediate Cause (Finat disease or condition	ZXSANG	0.21						Onset and De	ath
	/Medical Examiner		resulting in death)	Due to (or as a conseq	ence of):							
		iii	Sequentially list conditions, b.	E LOS; On	J OP	ALIEN	OVER	1005 54	3			
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	200 10 (0. 00 00 00 00 00 00	23/103 01/.				AI	M		
o,	an andrial-tra	Exa	resulting in death) Last	Due to (or as a consequ	uence of):							
68760,	tificate be executed Ig physician and as the burial-transit	edical	d									
	ding p		IF FEMALE:	If yes, outcome of pregna	nov							
Вох	The law requires that the death cert ate has been signed by the attendingage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq 12 \) No	1☐Live birth 2☐Fetal 4☐Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			2	3d. Date of de Month	livery Day Yea	ar
P.O.	that the de led by the a detached f	hysi	9 Unknown	9 Unknown								
S,	res tha igned be del	by P	Part II. Other significant conditions contrib				in Part I.	23e. Did to	bacco us	se contribute (o the cause of dea	.th?
ord	w requir been si should	Completed	HIMASUSD	2010	CA!	359		1 🗆 Y	es 2 []No 3∏P	robably 4 🔀 ni	known
3ec	e law has b	mple	SNO STAGE	LENAL DI	5 F A 3	E		24a. Was a autop perfor	sy	24b. Were an prior to death?	utopsy findings ava completion of caus	ailable se of
Vital Records,	sicien: The law certificate has b irector, page 2 s		OF Westernation					1 ☐ Yes	2 Q No	1 Yes	2 2 10	
	iysicien: nis certifica director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2 🛱	ER/Outpatien			eath <i>(Check only or</i> Home 5 - Resid		Cothes (See	a16.1	
Division of	Attending Physicien: r death. ector: After this certification by the funeral director.	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at	28d. Describe h			Ciry)	
Sio	endir eath. or: Af	atic	2 Accident investigation	(,		os 2□No	9				
<u>X</u>	l or Attencatter death after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of Injury - At ho building, etc. (Specify 		eet, factory, office		28f. Location (S City or Tow	itreet and m, State)	Number or R	ural Route Numbe	Γ,
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by		29a. Certifier 1 ☐ Certifying Physici	en: To the best of my know	wledge death	occurred at the time	date and place	e and due to the a	21160/0)	and manner -	etatod	
	ne Hos ne Fur letely	Medical	(Check only one) 2 Medicel Exeminer	: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my opin	nion, death occ	urred at the time, o	date and	place, and due	to the cause(s)	
	To th withir To th comp	M	29b. Signatura and title of certifier			29c. License		2	29d. Date	signed (Mont	h, Day, Year)	
			- yourshit	1-h-	M-D.	021	809		~00	23	2005	
1	BHIVA		30. Name an address of person who comp					040		1 -	-	
200	Sta	0	31. Date filed (Month, Day, Year)	32. Registrar's Signat	6 7 0	ME NOA	10 11	10 NIUN	7	5 21	093	
Y	Jia	36	NOV 2 9 2005	March 116	11 4							1

PARRETT, ELMER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** November 22, 2005 2:30 A.M Ethel M. Raphael /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye June 25) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1915 New York, N. Y. 1□M 2□F 90 Director 066-10-6268 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified an once. Yes 2 No Directo Montgomery Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U. S. A. 2817 Village Lane by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Years Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augusta Berkowitz Joseph Dunieff ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2655 Creston Drive, Los Angeles, California 90068 Ellen Raphael Collins - Dgt. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 【 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11-26-05 Alexandria, Virginia 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. Donald 1170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Print and Death Immediate Cause (Final Cerebral Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to improve Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation **X**□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coronary Artery Disease autop sy perform 2**X** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 😿 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 2 Accident death. 1 Tes nours efter death nerel Director: / filled in by the fi 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel C 29a. Certifier 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ŝ 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) D006047 November 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland Eric J. Park, M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2016 7 0 Registrar

DHMH 17 Rev 1/2001

Raphael, Ethe

exp 11/22/05

			For State Registrar	State	of Maryla		artmer <i>rtificat</i>				lental H	ygiene Reg. Ne		5	40)41
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	/Medic Examin		4a. Facility Name (If not institution Alfred House El	-	umber)			Town, or		of Death			County of		y	
	Funeral Director	00	5. Social Security Number 099-07-1574	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	. last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, I July	Dav. Year	1916	9. Birthp Court New	lace (Stantry) Yor	te or Foreign
ours after death with the Maryland	and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ehow reumatic event, the Medical Examinar must be notified at	Funeral Direc	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo 10e. Street and Number 5313 Norbeck 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Road 12. Was De	cedent Ever in Forces? Solve		7 i11 e	p Code 20 edent of Hiseofly Cuba)853 spanic Or n, Mexical Specify:		ecify Yes or Rican, etc.)	Unit	14. Race	ates	otry? of	
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E	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and positive completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and the funeral director.	dicai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Deme Due t b. Park Clist		Diseas	se								Onset a	Between and Death
the death certific	y the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □ Live	outcome of preg birth 2 Fe gnant at time ot known	tal death 3	⊒Ectopic p ⊒ Other (s				=-	-	23d. Date Mon		ery Day	Year
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DHMH 17 Rev 1/2001

Registrar

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	Physici	an	1. Decedent's Name (First, Midd	ile, Last)				2. Date of Deat Month		Year 3	. Time of Dea	th
	/Medi		Frederick M.	Rupply				Novembe:	r 26 2	005	9:15	\mathbf{p}^{M}
	Examir	ner	4a. Facility Name (If not institution			4b. City, Town, or			4c. County of	of Death		-
			Westminster Nur 5. Social Security Number		enter 7. Age (In yrs. last birthday)	Westm	inster If Under 24 Hrs.	10 Day (10)		rroll		
	Funeral Director			1 ½ M 2 ☐ F		Months Days	Hours Min.	(Month, Day,		9. Birthplace Country)	State or For NY	eign
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	ith th	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of W	hat Country?)	
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	er de Itams	Funeral	11. Marital Status	Armed Ford	dent Ever in U.S. 13. ces?	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Dican, etc.)		- American I	ndian,	
36	rs aft	by F	1 ☐ Never Married 2 🖾 Ma 3 ☐ Widowed 4 ☐ Divorce	It The Give	is. WW2	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Whi	te	
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	al Hy t other vant,	Bec	17. Father's Name (First, Middle	, Last)			18. Mother's Nam	e (First, Middle, N	faiden Surname	a)		
yla	2 should be filed withir and Mental Hygiene. is markad othar than aumatic avant, Ite M.	10	Joseph A. Rug	ply			Jessie	Malinos	ci			
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	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic event, Ite Medical Examinating the matified at	0	Patricia A. Ru	ibbī\mrie		Baust Chi					1158	
ور	Pages nent of th int: If its		20a. Method of Disposition 1 Durial 2 Cremation		late	matory or other place	9)		20c. Location - C			
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Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 ti any injury or other tra 9008.	li o	111	7		Name and Address Pritts Fur 412 Washir	arton Pos	Typody be	sinctor		21157	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that can t only one cause on ear	used the death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	st,	App	proximate erval Between	
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}	HILL		>	James.	sel	1000	59943	N	102mbe	V 28	2005	
	127		30. Name and address of	who completed cause	of death (Item 23a) (Type,	Print)		/ ,		91		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	arylari	-	ertificate o		iu ivientai n	ygier Reg. i	2000	40043
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	/Medic		Levin Willia		nsor	ı Jr.			11	17	7 2000	
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	ylanc how		10a. State 10b. County		10c. Cit	ty, Town or L	ocation					10d. tnside City Limits
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	or 28	Oire	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	ountry?
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36	rs aft	byF	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2.20 If Yes, Give Year or Dates:	NO		1□Yes 2XN	lo Specify:			Specify: p.1	ack
9	within 72 hours after death with the Marylan ene. than "naturel", or Iteme 23a or 28a-f show he Modical Examiner must be notified at	ted	15. Decedent's E	ducation		16a. Dec	edent's Usuat Occ	upation		16b.	Kind of Business	
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Z Sa	ould Men Marke	2	Levin William		Sr.				Price			
Maryland 21215-0036	12 st h and 7 ie m traum		19a. Informant's Name/Relationship			1			or Rural Route Num			
	1 and Healt em 2		Sara Robinson (20a. Method of Disposition	wire)	20b. F	Place of Disc	I Read	or cre	eek Rd.Q1	-	tico, Md Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than eny Injury or other traumatic event, the Mannes.		1 Burial 2 ☐ Cremation 3		1		osition (Name of ematory or other p					
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-28- L 68760,	physicate sthe	Aedicai		d								
	certif ding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy					23d. Date of del	liven
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on s, P	es tha igned I be det	y P	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco	o use contribute to	the cause of death?
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√ ×	or A after Direction by	ertif	4 ☐ Homicide determined	building, etc	c. (Specif	y)	treet, factory, offic	e	City or To	own, Sta	and Number or Hi ite)	ural Route Number,
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			1 - For State Registrar	State of Ma	aryland	-	rtmen			and M	lental Hy	giene) [10011	
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	/Medio Examir		4a. Facility Name (If not institution, give well) Woodside Center						Location o		Noveml	4c. Cour	2005 hty of Death	1	
100	Funeral Director		5. Social Security Number 6. Sex	1 M 2077 E	e (In yrs. las	st birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Mar. 8	th ly, Year)	Cou	ry nplace <i>(State or Forei</i> <i>intry)</i> nsylvania	_
	Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County D • C • N/A			Town or Lo								10d. Inside City Limi	its
	ath with the 23a or 28s	rai Director	10e. Street and Number 710 VanBuren Stree	et, N.W.		-5112116	10f. Zip	Code				10g. Citizen o			
9800	2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. I le marked other than "natural", or Iteme 23e or 28e-f show raumatic event, its Modical Examinat must be multised as	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🏿 Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:		li li	Vas Deced Yes, spec	offy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	В	lack, White	ican Indian, , etc. American	
Maryland 21215-0036	d within 72 h jiene. r than "natu ir e Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12				ent's Usua kind of wor DO NOT us rviso	rk done d se retired)	tion uring most	of worki	ing	16b. Kind of	Business/l		
yland	m - 0 =	To Be C	17. Father's Name (First, Middle, Last) Richard K. Waddy						Lucy	y Re	e (First, Middle, becca F	Maiden Suma 'leming	ame)		
re, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Ie marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Ty) Estelle S. Weaver 20a. Method of Disposition	_{рө, Print)} (daughte	20b. Plac	710 V	an Bu	iren	Stree	et,]	N.W. W		.c.	20012	
Baltimore,	epartment o epartment o oportant: If I ny injury or		1 Burial 2 □ Cremation 3		1	ngahe	la Ce	mete	ry		3/05 Guire F	North I	Bradde Serv	ock, PA	
300			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	ne cause on each lir	10.	Do not ente	r the mode	e of dying	, such as o	cardiac c			.c.	Approximate Interval Between Onset and Death	
8/60,	Physician /Medical Examiner be executed bhysician and bhysician and stile private transit superprivate by the private beautiful and the private by the priva	ai Examiner	disease or condition resulting in death) Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Dement Due to (or as Due to (or as	a conseque I tia a conseque	nce of):	Card	iova	scula	ır Di	Lsease			years years	
.O. Box 68/	I the death certif by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3 🗍	Ectopic pre Other (spe						eate of deliver	ery Day Year	
cords, r	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bu	at not resulti	ng in the un	derlying ca	tuse giver	n in Part I.			obacco use co res 2 X No		the cause of death?	'n
He He	The law ate has b page 2 sl	e Completed	26 Was seen selected to medical								1 ☐ Yes	osy rmed? 200 No	. Were auto prior to co death? 1 Yes	opsy findings available in the properties of the	le
0	Phy	ToB	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	ospital: 1 □ Inpatie 28a. Date of Injur (Month, Day		VOutpatient Bb. Time of Injury		A Other Bc. Injury Work?	4 🔯 Nur	sing Hon	Check only one 5 Residence	dence 6 🗆 O		(y)	
DIVISION	pital or Atte	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	: (Specify)						City or Tou	vn, State)		al Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier (Chack sh) 29b. Signature and title of certifier	ician: To the best of the basis of and manner sta	examination	edge, death n and/or inve	estigation,	t the time in my opi	nion, death	place, a	ed at the time,	date and place 29d. Date sign	, and due to ed (Month,	o the cause(s) Day, Year)	
•	8		30. Name and address of person who con		eath (Item 20		rint)		20		8		22/0		-
	Sta Registr		Rakesh Arora, M 31. Date filed (Month, Day, Year) NOV 28 20	D. 1430			ox L	ane S	Suite	222	, Bowi	Le, MD	2071	5	

			For State Registrar	State c	f Marylan	id / Depa	artmen	t of H		Mental Hy		е	1.0016
	Physic		Decedent's Name (First, Middle RONALD ROBER							2. Date of D Month Novemb	eath	.5,2005°	3. Time of Death 2:30pm M
	/Medi Examir		4a. Facility Name (If not institution Suburban Hosp		mber)			Town, or hesd	Location of Dea		40	County of Dea Montgom	th
	Funeral Director		5. Social Security Number 120-32-4346	6. Sex 1 (X)M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under 24 Hr Hours Mir		irth lay, Year, Y 5,	1940 Yo	thplace (State or Foreign ountry) NKETS, NY
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	vith the Maryland t or 28e-f show	ector	MD Montg	omery	S	ilver S							1 X Yes 2 ☐ No
	23a or	al Dir	3330 N. Leisur	e World B	lvd.		10f. Zip	2090	6			itizen of What Co	•
036	tiled within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or iteme 23s or 28e-f show ont, the Madical Exandral must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed Fo	2 □ No		Was Deced f Yes, spec l □ Yes		spanic Origin? (n, Mexican, Pue Specity:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	within 72 hours iene. 'than "natural', the Wed Gal Ext	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed)	1-4or 5+)	16a. Deced (Give life. I	kind of wo DO NOT u	rk done d se retired	luring most of we	orking	16b. K	ind of Business	Andustry
- 06 Maryland 2	B E D	To Be Co	17. Father's Name (First, Middle, Matt Shifrin						Louise I		e, Maider	n Sumame)	
	- m	1 19	19a. Informant's Name/Relations Judie Shifrin/							ural Route Numb			Zip Code) MD 20906
2 / S	Pages 1 and 2 should ment of Health and Men ant: if Item 27 is marke ury or other traumatic	1	20a. Method of Disposition 1 → Burial 2 □ Cremation		State 20b. P	lace of Dispo emetery, cren	sition (Nar	ne of ther place	a)	Date		ocation - City or	
11-25 Baltimore	permit. Pages i Department of H Important: if ite any injuty of pt once.		4 Donation 5 Other (S		Mt.		. Name an	d Addres	s of Facility	05-27-05 Soseph G	awle:	r's Sons	on Hudson,NY s,INC OC 20016
	Physician		23a. Part1. Enter the dispase, or shock, or heart fail re. List Immediate Cause (Final disease or condition resulting in death)			n. Do not ente	er the mod	e of dying					Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions,	Due to	(or as a consequence of the consequence)	uence of): 7Cu to	aus	K					(omo
8760.	n certificate be executed anding physicien and use as the burial-transit	Ical Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence of the conse	uence ():	dų:	sple	SIA				lomo
CD Box 6	it the deatl by the etter tached for	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live b	come of pregna pirth 2 Tetal ant at time of de	Ideath 3	Ectopic pr Other (sp					23d. Date of deli Month	ivery Day Year
ONA P.O.	w requires tha been signed should be de	ρ	Part II. Other significant condition		FULL V		derlying c	ause give	n in Part I.			/	the cause of death?
tal Reco	ió -	Completed	25. Was case referred to medical			- 7.				1 ☐ Yes	psy ormed? 2 No	death?	topsy findings available completion of cause of
S V	ding Physician: n. After this certifica funeral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1		ER/Outpatient		A Othe	r: 4 🗆 Nursing I	ath <i>Check only</i>		6 □Other (Spec	city)
ion	ding Afte	atlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig		of Injury th, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ′es 2 ∐No	28d. Describe	how injur	ry occurred	
Divis	or Ati	Certification:	3 Suicide 6 Could determ	ined 286. Place buildir	of Injury - At ho ng, etc. (Specify	′) 				City or Fo	wn, State)	ral Route Number.
1	24 h	Medicai	29a. Certifier 1 Certifyin (Check only 2 Medical one)	i g Physician: To the E xaminer: On the ba and mann	asis of examinat	wledge, death tion and/or inv	occurred a estigation,	at the time in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the Comple	W	29b. Signature and title of certifier Mula	nomai.	KWEU	e Mi	290	License	14722	2_	29d. Dai	signed (Month	n, Day, Year)
(5)		30. Name and address of person Melissa Me					Geor	getown F	Rd,Bethe	sda.	MD 20814	4
7	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 28		egistrar's Signal		-						

,			1 - For State Ragistrar		State of	Maryla		artmen rtificat				fental Hy	Reg. No.	005	- 4	004	6
	Physici	an	Decedent's Name (First, Midd		G1							2. Date of De Month		Ye	ar	3. Time of D	
	/Media	cal	Dorris	Ε.	She				-	1 0		Novembe				6:30P	M
	Examir	er	4a. Facility Name (If not institution 7420 Westlake	-		^{жег)} #803			Town, or nesda	Location of	of Death			ounty of D			
	Euparal		5. Social Security Number	6. Sex			. last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi		_		ce (State or I	Foreign
	Funeral Director		579-20-6045		2 TF	82		Months	Days	Hours	Min.	8. Date of Bio (Month, Da March	ay, Year) 14, 1	923	Country	ce (State or I	oraigir
	P ,		Usual Residence of Decedent														
	anylau show	7	Maryland Mont		·v		ity, Town or Lo Betheso								100	d. Inside City 1 X Yes 2	
	he M	Director	10e. Street and Number											4			: _ 140
	with I	ā	7420 Westlake	Томи		#803		10f. Zip		0817				on of What		•	
	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23e or 28e-f show ant, the Medical Examinat must be notified at	Funerai	11. Marital Status		. Was Deced		J.S. 13.	Was Decec			gin? (Sp			1 Sta 1. Race - A		of Am	eric
9	or Item	F	1 Never Married 2 Mai		Armed Ford	es? XNo						ecify Yes or No Rican, etc.)		Black, W	/hite, et	c.	
03	rel', o	by	3	1	If Yes, Give Year or Dat	es:		1 Yes	2 💢 No	Specify:			5	Specify:	Whi	Lte	
21215-0036	72 hc netu	Completed	15. Deceder (Specify only higher				16a. Dece	dent's Usua kind of woo DO NOT us	al Occupa	ation during mos	t of work	ina	16b. Kin	d of Busine	ss/Indu	stry	
121	vithin ne. hen.	mpi	Elementary/Secondary (0-12)	Ī	College (1-4	lor 5+)											
2	iled v Hygie ther t		12 17. Father's Name (First, Middle)	[25t)			Home	emake	<u>r</u>	19 Moths	ore Nome	e (First, Middle		1 Hom	e		
an	d be antal l	Be c	Harry Elste									Gudensl		umame)			
Maryland	2 should be filed within and Mental Hygiene. 'is marked other then "reumetic event, the Men	ဥ	19a. Informant's Name/Relation		, Print)		19b. Mailir	na Address	(Street a			al Route Numb		Town. Stat	e. Zip C	ode)	
	and 2 ealth ar n 27 is		Susan S. Kaye	- Da	ughter	<u>-</u>						ithersh					
ē,	s 1 and 3 of Health item 27		20a. Method of Disposition			20b.	Place of Dispo cemetery, crei	sition (Nan	ne of	e)	[Date	20c. Loc	ation - City	or Tow	n, State	
Ë	Page in the page		1 P Burial 2 □ Cremation 1 Donation 5 □ Other		noval from St	ale	dean Me			1	11/	27/05	Olne	ey, M	arvl	and	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. importent: if item 27 is marked other then "neturel", or items 23e or 28e-f show eny finiting or other treumetic event, the Medical Examiner must be notified at ODGE.		21. Signature of Funeral Service	Licensee	`	,	Ec	Name and	d Addres	s of Facility		l Direc					
	- Y		23a. Part. Enter the disease, o shock, or heart failure. Lis	r complica	tions that cau	sed the dea									A	approximate nterval Betwe	
П	Physician		Immediate Cause (Final disease or condition	only one			Lung (Cancei	c							nset and De months	ath
	/Medical		resulting in death)	(a	Due to (or	as a conse	quence of):								+-		
	Examiner		Sequentially list conditions,	b													
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ł	Due to (or	as a conse	quence of):										
	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	С.	Due to (or	as a conse	quence of):								1		
8760,	death certificate be executed e attending physicien and of for use as the burial-transit																
9	ifficate g physi as the t	edic											-				
Вох	leath certific attending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c	. If yes, outco			Ectopic pr	ognanav				23	d. Date of	delivery		
	deat death	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No		4☐Pregnar	nt at time of		Other (sp.						Month	Di	ay Yea	ar
P.0	that the dended by the added	Phys	9 Unknown								-						
Vital Records,	The law requires that the tee bas been signed by the bage 2 should be detache	by	Part II. Other significant conditi	ons contri	buting to dea	th but not re	sulting in the u	nderlying ca	ause give	n in Part I.						cause <i>o</i> f dea ly 4 ∑ Unk	
000	aw re	Completed										24a. Was				y findings ava	
Ä	The la	mo										autor perfo	ormed?	death 1 🔲 Y	?	letion <i>o</i> f cau: ⊡No	se or
ita	ician: Th certificate rector, pag	ВеС	25. Was case referred to medica examiner?	i						26. Place	of Death	(Check only o				X	
of V	di is	101	1 Yes 2 No	Hos	pital: 1 🗆 Inp	patient 2	ER/Outpatien	it 3 DO	A Othe	r: 4 🗆 Nu	rsing Ho	me 5 Resi	dence 6	Other (S	pecify)		
ū		on:	27. Manner of Death 1 Natural 5 ☐ Pendi		28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of Injury	2	8c. Injury Work	at ?		28d. Describe	how injury	occurred			
<u>s</u> i	eat or: he	cati	2 Accident invest 3 Suicide 6 Could	gation not be				М		′es 2 □ l							
Division	or Atten after deat Director: in by the	Certification:	4 Homicide determ		28e. Place of building	I Injury - At h , etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory	, office			28f. Location (3 City or To		Number or	Rural F	Route Numbe	1.
البط	Hospitel 24 hours a Funerel I		29a Certifier 177 Certifyi	an Physic	ian: To the h	est of my kn	owledge death	occurred :	at the tim	o dato an	d place	and due to the	001100(0) 0				
	24 h	edicai		Examiner	On the bas	is of examina	ation and/or in	vestigation,	in my op	inion, deat	th occurr	ed at the time,	date and p	lace, and o	lue to th	e cause(s)	
	To the Hospitel or Atti within 24 hours after de To the Funerel Directi completely filled in by t	Me	29b. Signature and title of certifie			1		29c	License	number			29d. Date	signed (Mo	nth, Da	y, Year)	
)	1		> Yoseph	M.	HRZZE	ity m	6)	1	33	240	7		Noven	ber 2	25,	2005	
	Q		30. Name and address of person	who comp	oleted cause	of death (Ite	m 23a) (Type,	Print)									
			Joseph M. Ha		y MD)	9707 N	ledica	al Ce	enter	Dri	ve, Roc	kvill	e, MI	20	850	
	Sta		31. Date filed (Month, Day, Year,		32. Teg	gistrar's Sign	ature	gets!									
8	Registr	aı	DEC 0	(200	100												

			State of Maryland / Department			
				rtificate of Death	Reg. No.	40047
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Ye	3. Time of Death
	Physici /Medio Examir	cal	Hazel Mildred Spahr 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11 22 2005 4c. County of D	7:15A M
			Carroll Lutheran Village	Westminster	Carro	
	Funeral Director		5. Social Security Number 212-62-4459 6. Sex 1 回 M 2 年 7. Age (In yrs. last birthday) 1 以 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Birthplace (State or Foreign Country) aryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary s-f sh	tor	MD Carroll Hampste	ead		1 ☐ Yes 2 ☐ No
	or 28,	Olrec	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
	s 23a	ral	4006 Shiloh Ave.	21074	USA	
10	fter de ritem iner	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 1 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	merican Indian, /hite, etc.
036	72 hours after death with the Maryland natural', or items 23a or 28a-f show dieal Exemirer must be notified at	1 by	1 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2∰ No <i>Specify:</i>	Specify:	hite
21215-0036	"natu	Completed by Funeral Director	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b. Kind of Busine	ess/Industry
212	iene.	omp	Elementary/Secondary (0-12) College (1-4or 5+) Te a	icher	Educati	.on
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heatih and Mental Hygiene, ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, tra Medical Examinar must be neithed at 8.	Be C			e (First, Middle, Maiden Sumame)	
Maryland	should be to the Mental I is marked of umatic even	To	Wesley Osborne Snyder		Melvina Weave	
Mar	d 2 sho th and 7 is mu trauma			Ghilob Arro II	•	
	Health tem 27 other tr		Miriam V. Sinnott - Daughter 4006 20a. Method of Disposition 20b. Place of Dispo	sition (Name of	Date 20c. Location - City	21074 or Town, State
OIII	Pages nent of I ant: if it		t #1 Bunal 2 □ Cremation 3 □ Hemoval from State □ .	Cemetery 11-2	26-05 Hampste	ad, MD
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other trongore.			2. Name and Address of Facility E1:		
	20 E # 9		Sleven W. Cline 9	34 South Main S	Street Hampste	ad MD 21074
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	or the mode of dying, such as cardiac of	Distance	Approximate Interval Between Onset and Death
Н	Examiner		Sequentially list conditions, b	/		0
-	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Ć	sician and burial-transit	Exar	that initiated events c c Due to (or as a consequence of):			
3760	ate be nysicia he bur	Ical	d			
x 68	entifica ding ph	/Med	IF FEMALE:			
P.O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)	23d. Date of Month	delivery Day Year
Records, P	The law requires that the ate has been signed by the page 2 should be detache	by	Page Other significant conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting to death but not resul	nderlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	e to the cause of death? Probably 4 Unknown
Il Reco	hysician: The law r his certificate has be I director, page 2 sh	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes	
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner? Hospital:	- Other:	n (Check only one)	
of	□ + □	n: To	27. Manner eath 28a. Date of Injury 28b. Time of	28c. Injury at	me 5 Residence 6 Other (S 28d. Describe how injury occurred	pecify)
ion	Attending For death. ector: After by the funer.	atlo	1 atural 5 ☐ Pending (Month, Ďaý Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	7 2 7 -	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	set, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral Completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(s) and manner red at the time, date and place, and d	as stated. lue to the cause(s)
	To t To t	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth. Day, Year)
7	MJL		Wester Cer. D.O.	H205584	11/22/	2005
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	STESTHIN STEX	Jud. 2115	-8
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	NOV 2 8 2005 Slesin &	parti		

			1 For State	State of Maryland		artment of Hertificate of D			2005	1,001,0
			Registrar 1. Decedent's Name (First, Middle, Las	:t)		tineate of L	,cairi	2. Date of Deat	ng. No. Co	3. Time of Death
	Physici	ian	Wilson 8	ugene		Singe	h	Month	Day Year	J.///S M
230	/Medio		4a. Facility Name (If not institution, give	7		4b. City, Town, or		11 2	4c. County of Death	17470 "
for	Examir	ner							1	1
			Carroll Hospit 5. Social Security Number 6. S		et hirthday)	Westmi If Under 1 Year	nster If Under 24 Hrs.	8. Date of Birth	Carroll	nplace (State or Foreign
	Funeral Director			∰ ^{M 2□ F} 79	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Cou	intry)
			Usual Residence of Decedent	"				12-04	-1925 Ham	pstead MD
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Man, -feh	ţō	MD Carrol	1 360	5 Sh	iloh Rd.	Uamne+	0.24		1 ☐ Yes 2 ☐ No
	28a	Director	10e. Street and Number		J D11.	10f. Zip Code	namps t		Og. Citizen of What Cou	untry?
	3a ou		3605 Shiloh Ro			21074				,
	deeth me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		Was Decedent of His	panic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amer	ican Indian,
(0	ifter c	Ē	1 ☐ Never Married 2 ☐ Marned	Armed Forces? 1#⊒Yes 2 ☐ No		f Yes, specify Cuban	i, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
ဗ္ဗ	er. o	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WWI	I	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ite
9	within 72 hours after deeth with the Maryland ene. Then "neturel", or Iteme 23a or 28a-f ehow ha Medical Examinar must be notified at	Completed	15. Decedent's Ed			dent's Usual Occupat			6b. Kind of Business/I	
2	Pin 7	ed d	(Specify only highest gra	College (1-4or 5+)	life. I	kind of work done du DO NOT use retired)	aring most of work	ing		
2	gien gien	PO	10		Equi	oment Op	erator	(Construct	ion
9	e filed al Hygie other vent, II	Be	17. Father's Name (First, Middle, Last)		1 1		18. Mother's Name			
<u> </u>	ould be Mental arked o	To E	Charles Edward	Singer			Magic T		Weaver	
∺	should and Men e marke		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street ar	nd Number or Run	Al Route Number,	Weaver City or Town, State, Zi	ip Code)
	and 2 eelth a n 27 ie		Genevieve M. S	inger, Wife	3605	Shiloh	Rd. Ham	pstead	, MD 210	74
altimore,	-135		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place			20c. Location - City or T	own, State
Ĕ	Pages nent of int: if it		1					9/2005	Hampstea	d, MD
=	permit. Depertm Importa any inju		21. Signature of Funeral Service Licen		-	. Name and Address	of Facility			
m	Depermine the permine the perm		Stower (A)	Floris MODE	27 9	34 South			neral Hostead, MD	
			23a. Part1. Enter the disease, or com	lications that caused the death.						Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	11					Interval Between Onset and Death
<i>)</i>	/Medical		disease or condition resulting in death)	a. Due to (or as a conseque	7 /					1415
н	Examiner			Due to (or as a conseque	ince or).					
		ē	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	nce of					<u> </u>
	ned Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
<u>,</u>	al-trä	Xa	resulting in death) Last	Due to (or as a conseque	ince of):					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical		4						
89	ficat g phy is the	edlo		u						
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					23d. Date of deliv	renv
m	eath atte	clai	in the past 12 months?	1 Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
o.	t the de by the t	ıysi	1 Yes 2 No 9 Unknown	9☐ Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
T	The law requires that the tee has been signed by th rage 2 should be detache	4	Part II. Other significant conditions of	ontributing to death but not result	ing in the ur	nderlying cause giver	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	uires Sigra Id be	d by						1 ☐ Ye	s 2 No 3 Pro	bably 4 Abnknown
Ö	w require been si should I	Completed						240 1460 00	045 14/2	
ě	has pe 2	E						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
								1□ Yes 2		2 □ No
Vital	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death			
<u></u>	Phys this aldii	2	1 Yes 2 No 27. Mann of Death	1 □ Inpatient 2 ► El	R/Outpatien		4 Nuising no		nce 6 ☐Other (Speci	fy)
5	ding l	0	1 ⊬Natural 5 ☐ Pending	(Month, Day Year)	8b. Time of Injury	Work?	,	28d. Describe how	w injury occurred	
Division of	uttendi death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be				es 2 No	20(1 1' /2)		
2	or At efter d Direct	it.	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, rarm, stre	eet, ractory, office		City or Town,	eet and Number or Run State)	al Houte Number,
	To the Hospital or Attending Physician: within 24 hours deflar death . To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	reiciant To the best of multiperior	odgo dosti		data == 1 1			
	Fun Fun	Medical	(Check only 2 Medical Exam	ysician: To the best of my knowl iner: On the basis of examinatio and manner stated.	n and/or inv	estigation, in my opi	nion, death occurr	and due to the car ed at the time, da	use(s) and manner as : te and place, and due t	stated. o the cause(s)
	ithin o the	Me	29b. Signature and title of certifier	and maining stated.		29c. License	number	٥٥٠	d. Date signed (Month,	Day Year)
				The D						
•	MJL		no war		10-1 =	W 3/	000	-101	,0,10	
	6		30. Name and address of person who or Robert Richts 31. Data filed (Month Day Year)	completed cause of death (Item 2	:за) (Туре, I	Print) 2	1.Ste	MID ?	2115	
			31. Date filed (Month, Day, Year)	32. Regetrar's Signatur	- W	المارار الا	-3/-/			
	Sta	te	NOV 9 0	oz. vio	An	1				

			1 - For State Registrar	State of Mary		artmen rtificate			nd M		giene	005	1	+00	49
	Physici	ian	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Ye	ar	3. Time of	f Death
	/Medi	cal	Lamana Almed							Novembe	er 22	200	5	3:21	РМ
1	Examir	ner	4a. Facility Name (If not institution, give some Citizen's Nursing				Town, or deri	Location of	Death			County of E		,	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)			If Under 24	4 Hrs.	8. Date of Birt					or Foreign
	Director		220-16-1652	IM 2 X F	83 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Aug . 24	, 1922	2 1	Count 1ary	ace (State of try) land	or i oraigir
	pu 🛾		Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or Lo										
	Aaryla I sho	ō	MD Frederi		-	odsbo	ro						10	0d. Inside C 1 ☐ Yes	2 No
	28a-	rect	10e. Street and Number			10f. Zip					10a Citiz	en of Wha	t Count		
	h with	I D	11108 Dublin Rd	•			217	98				.S.A.		.,,.	
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Ever if wit rust be indiffed at	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces	in U.S. 13.	Was Deced	ent of Hi	spanic Origi	n? (Spe	cify Yes or No- Rican, etc.)	. 1	4. Race - A			
36	or It	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2			I donto I	noari, etc.)	}	Black, V Specify: V			
8	hour:	Completed by	15. Decedent's Edu	Year or Dates:	162 Dogo	dent's Usua	1.000000								
15	nin 72 n "na Nedic	plet	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done d	u <i>rina m</i> ost c	of workin	ig	16D. KIN	d of Busine)ss/ina	ustry	
212	d with giene ar tha	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	seams	tress					se	wing	fac	ctory	
pu	be file tal Hy d oth avant	To Be (17. Father's Name (First, Middle, Last)	c c						(First, Middle,		u <i>mame)</i>			
yla	Meni Marke Marke Marke	2	Elmer J.D. Schae							ay Dice					
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Ever, it with out the tradified at ODGs.		19a. Informant's Name/Relationship (Ty) Clinton W. Smith		19b. Maili 111	ng Address 08 Du	(Street a blin	Rd. V	or Rural Nood	Route Numbe sboro,	r, City or MD 2	Town, Stat 1798	ө, <i>Zip</i> (Code)	
Baltimore,	of He of He If itam or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	emoval from State	Ob. Place of Dispo cemetery, crei	matory`or ot	her place			ate	20c. Loc	ation - City	or Tov	wn, State	
Ë	Pag tment tant: jury c		`4 □ Donation 5 □ Other (Specify)		Rocky Hi	11 Ce	mete	ry 11	1/25	/2005	Wood	sboro), M	1D	
Bal	permit Depar Impor any in		21. Signiture of Edheral Service License	"XJartx	or/	2. Name and 04 S.				artzler odsbord				1е	
8760,	Physician /Medical Examiner and the prize and the prize transit the prize transit tran	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a cor	.sequenze ul).	1	d ;	5-195-	e					Interval Bet Onset and I	
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	Bc. If yes, outcome of print Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pre					23	d. Date of Month	-		/ear
Records, P.	signed I	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	44	,	e to the	cause of d	eath? Jnknown
COL	w requir	Completed					-		_	24a. Was a		\		sy findings a	<u>-</u>
Re	The lay cate has page 2:	фщо								autops		prior death	to com	pletion of ca	
Vital		O	25. Was case referred to medical					26 Place of	f Death	1 ☐ Yes :		1 🗆 Y	es 2	2□ No	
Į V	dis d	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatien	t 3□ DO	Othe	100		e 5 Reside	-	—— ⊒Other (S	pecify)	2 - 1 - 2	277
n of	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28	c. Injury Work			3d. Describe ho					
sio	tan leat tor: the	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2□No	-						
Division	sal or Attanos after death	Certification;	4 Homicide determined	28e. Place of Injury . building, etc. (Sp.	At home, farm, str pecify)	eet, factory,	office		28	Bf. Location (Si City or Town	treet and i n, State)	Number or	Rurali	Route Numi	ber,
	To tha Hospital or At within 24 hours after of To tha Funaral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, death nination and/or in	occurred a vestigation,	t the time in my op	a, date and p nion, death	place, ar	nd due to the ca	ause(s) a ate and p	nd manner lace, and c	as stat	ted. he cause(s)	
	To tha within 2. To tha complet	M	29b. Signature and title of certifier	1		29c.	License	number		2	9d. Date	signed (Mo	onth, D	ay, Year)	
)	112		Hunk	the and		I	0003	1058				11–23	-05		
	MA		30. Name and address of person who con			,									
			Gene F. Ashe, M. 31. Date filed (Month, Day, Year)	D. 10200 Co	oppermin	e Road	1, W	odsbo	ro,	MD 217	98				
	Sta Registr		NOV 2 8 20	05 Alseur	ignature	parti	f								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2005 November 5:00P Elaine Stong /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 4210 Bark Hill Rd. Union Bridge | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Aug. 26, 1934 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K 196-28-4626 71 Yrs Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examble minist be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Directo Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4210 Bark Hill Rd. 21791 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: <u>۾</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry private & al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) public schools teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked ott Be Albert Harrison Stong Eula Mae Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Mary E. Stong/ sister P.O. Box 400 Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Stong Family Cemetery 11/26/2005 nr. Uniontown, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signity of Faneral Service Lipense 22. Name and Address of FacilityHartzler Funeral Home atharine New Windsor, MD 21776 310 Church St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be No 1 🗌 Yes 3 Probably 4 Unknown Completed peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed? this certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home No 1 🗌 Yes 1 🗌 Inpatient 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) MSL completed cause of death (Item 23a) (Type, Print) 4 31. Date filed (Month, Day, Year) 32. Regiorar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:47 a.M Kieran Toine November 19, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Silver Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 12 M 2 ☐ F Months Days Hours 154-50-2618 Yrs 49 Director July 20, 1956 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Director Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1912 Flowering Tree Terrace 20902 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after Yes 2 Yes, Give 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifiWhite ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1976-81 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse permit. Pages 1 and 2 should be lited w
Department of Health and Mental Hygier
Important: If item 27 is marked other ti
any injury or other traumatic event. Health Care other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pross Toine Virginia Saunders 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. O'Hare/Partner 1912 Flowering Tree Torrace, Silver Spring, M ce of Disposition (Name of Date 20c. Location - City or Town, State MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 29, Williamstown, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Church Cemetery 4 □ Donation 5 □ Other (Specify) 2005 New Jersey 21. Signature of Huneral Service Licensee Francis Address Collins Funeral Home Inc ole 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hypercholesterolemia Due to (or as a consequence of): Box 68760 attending physicien The law requires that the death certificate be ician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached Physi á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 Smoking 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √ Yes 2 □ No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Injury 1 € Natural 2 ☐ Accident 5 Pending after death. М 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D62855 November 23, 2005 10+1 iddress of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Sean Stewart, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature **NOV 28** 2005 Registrar

		1	For State Registrar	State	of Maryla		irtment <i>tificate</i>		ealth and M Death		giene Rag. No.	005	40052
7,	35° 4		1. Decedent's Name (First, Middle, I	ast)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia		ANTHONY SALVI TRAVAC	GLINI						NOVEMBER			1:30 A M
	/Medic Examin	_	4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City, T	Town, or	Location of Death		4c.	County of Deatl	h
	340		HOLY CROSS HOSPITAL				SILVE	R SPR			MO	NTGOMERY	
	Funeral	Dice.		. Sex	7. Age (In y	rs. last birthday)	If Under		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year	Co	hplace (State or Foreign untry)
	Director		080-24-8379	1⊠M 2□F		73 Yrs.	William	Duyo		FEBRUAR	75,1	932 NEW 1	YORK
	6		Usual Residence of Decedent		140-	Oh. Taranala							10d. Inside City Limits
	how		10a. State 10b. County		100.	City, Town or Lo	cation						1 ☐ Yes 2 🗓 No
:	a-f	cto	MARYLAND MONTGOME	RY	S	ILVER SPRI							
	or 28	Jire	10e. Street and Number				10f. Zip	Code			-	zen of What Co	untry?
	72 hours attar death with the Maryland "natural", or iteme 23a or 28a-f ehow tdical Examinar must be nutified at	Funeral Director	12216 CONNECTICUT A	VENUE			209				U.S		
	dea me	ne	11. Marital Status	Armed I		n U.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	 14. Race - Ame Black, White 	
9	or it		1 ☐ Never Married 2 ☐ Married	d 1 ∑ Yes	2 □ No Give	0.56	1 🗆 Yes 2	2⊠ No	Specify:			Specify:	TTE
3	uraf',	d by	3 Widowed 4 Divorced	Year or	Dates: 195						10h K		ITE
ก็	72 h 'natt	Completed	15. Decedent's (Specify only highest	Education grade completed	d)	16a. Dece	dent's Usua kind of wor DO NOT us	k done d	ation during most of worl	king	160. KI	ind of Business/	industry
V	of this	ldu	Elementary/Secondary (0-12)	College	(1-4or 5+)	OPTICIA		e remed)		7	/ISION	
7	ygier ygier hartl		12	not)		OPIICIA			18. Mother's Nam	ne (First, Middle			
and	be fill ital H id otl	Be	17. Father's Name (First, Middle, La								,	UNKNO	.INI
) N	ould Men Marke Marke	၉	FRANCIS TRAVAGL			40h M-111	- A delugae	/Ctront	ANTO INETTE		er City o		
Mar	2 sh and fe m		19a. Informant's Name/Relationshi										
က် -	and ealth m 27		ALICE TRAVAGLINI/SP	OUSE	20	Db. Place of Dispo			AVENUE, SI	LVER SFR		ocation - City or	
0	if ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3	Removal fro		cemetery, cre	matory or o	ther plac	Θ)				
E	Par in Ba		4 Donation 5 Other (Spe		F	ORT LINCO				5/2005	BREN	NTWOOD, M	ARYLAND
Baltimor	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryiat Department of Health and Mental Hygiens. Department of Health and Mental Hygiens in returnst, or items 23a or 28a-1 ehow eny injury as other traumatic event, the Mudical Exercition must be notified at once.		21. Signature of Funeral Service Li	censee /		H	INES-RI	NALD:	ss of Facility I FUNERAL I	HOME			
n	10 E 3 G		umanda	Juai	wig							PRING, MA	RYLAND 20904 Approximate
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	ompli€ations tha nly one cause or	it caused the in each line.	death. Do not en	ter the mod	e of cryin	g, such as cardiac	or respiratory	irrest,		Interval Between Onset and Death
	Pnysician	8 1	Immediate Cause (Final disease or condition	MYOC	ARDIAL 1	NFARCTION							LMMEDIATE
	/Medical		resulting in death)	Due	to (or as a cor	nsequence of):							271
N.	Examiner		Sequentially list conditions.			OTIC CORON	ARY ARI	CERY :	DISEASE				YEARS
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a cor	nsequence of):							
	cuter nd trans	Examiner	Cause (Disease or injury that initiated events	c	,	0							
Ö.	e exe ien a urial-		resulting in death) Last	Due	to (or as a cor	nsequence of):							
8760	icate be executed physicien and s the burial-transit	dicai	37	d									
9	intification of plants of a second	Med	IF FEMALE:										
Box	eath certifi attending p for use as	iclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Liv	outcome of pr e birth 2 🗌	Fetal death 3	□Ectopic pr		,			23d. Date of de Month	livery Day Year
	e dea he at hed fo	Sici	1 ☐ Yes 2 ☐ No		egnant at time known	of death 51	Other (sp	ecity) _					
P.0	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physi	9 Unknown Part II, Other significant condition	a a a a stribution to	doath but no	t reculting in the	undorhina a	20150 000	en in Part I	23e Did	tobacco	use contribute to	o the cause of death?
	res tha igned be det	þ	Part II. Other significant condition	is contributing to	death but no	it resulting in the	anderlying c	ause giv	on an an a				robably 4 Unknown
Records,	w require been si should b	ted											
ပို	e law r has be je 2 sh	pie						_		24a. Wa aut	opsv	prior to	utopsy findings available completion of cause of
m m		Completed									formed? 2⊠No	death?	s 2□ No
Vital	Attending Physician: r death. sctor: After this certifice by the funeral director.	Be	25. Was case referred to medical examiner?						26. Place of Dea	ath (Check only	one)		
>	Physic this ce al dire	2	1 ☐ Yes 2 ☒ No	Hospital: 1	□Inpatient	2 X ER/Outpatie			4 Hursing I			6 ☐Other (Spe	ecify)
0	ng Pt ter th	ï.	27. Manner of Death 1 ☑Natural 5 ☐ Pending		ite of Injury fo <i>nth, Day</i> Ye	ar) 28b. Time Injury		28c. Injui Wo		28d. Describe	how inju	iry occurred	
Ö	andir. ath. or: Af	atic	2 Accident investig	ation			М	1 🗆	Yes 2 □No				
Division of	r Atte	tif	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Fi	ace of Injury - illding, etc. (S	At home, farm, s pecify)	treet, factor	y, office		28f. Location City or T	(Street a own, Stat	nd Number or R e)	lural Route Number,
Ξ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:											
	houn uner uner		29a. Certifier 1 ☐ Cartifying (Check only 2 ☐ Medical E	Physician: To	the best of m	y knowledge, dea	th occurred	at the ti	me, date and place opinion, death occu	e, and due to the	e cause(s e, date an	s) and manner a id place, and du	s stated. e to the cause(s)
	he H in 24 in 6 F in 9 F	Medical	one)	and m	anner stated.								
	To T	Σ	29b. Signature and title of certifier	11	11		29	c. Licens	se number		290. D8	ate signed (Mon	u, Day, (Bai)
)	8		MINIMA	elaug.	By			D0233	38		NOVE	MBER 22,	2005
			30. Name and address of person										
			RICHARD P. DELANEY	, M.D., 1	500 FORE	ST GLEN RO	DAD, SI	LVER	SPRING, MA	RYLAND 20	1910		
1	St Regis	ate	31. Date filed (Month, Day, Year)	3 2005	egistrars	Signatur							
		4.71		1 4									

		-	For State Registrar	State of	Maryla	and / Depa	artment o			and Me		giene Reg. No.	005	40053
	Physicia		Decedent's Name (First, Midd: Rose Mary Tro								nate of Dea Month Novemb	Day		3. Time of Death 12:30P ^M
	/Medic Examin		4a. Fecility Name (If not institution		nber)		4b. City, To	wn, or l	ocation of		Novemb		County of Deat	
	LAGITHI		9940 Cottrell	Terrace			Silv	er S	Sprin	ıg]	Montgom	ery
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F		rs. last birthday)	If Under 1 \ Months D	Year Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Birt (Month, Da	h y, Year)	9. Birt	thplace (State or Foreign
	Director		577.42.9955	ILM ZQF	71	Yrs.				J	une 4	193	34 Was	hington,DC
	and	1	Usual Residence of Decedent 10a. State 10b. County	,	10c.	City, Town or Lo	ocation							10d. Inside City Limits
	Maryl f sho	ō	Maryland Montg	omery		Silver	Spring							1 ∑Yes 2 □ No
	1 the	Director	10e. Street and Number			V- · · · · · · · · · · · · · · · · · · ·	10f. Zip Co	ode				10g. Citi	zen of What Co	ountry?
	h with	a D	9940 Cottrell	Terrace			209	903				U.S	S.A.	
	ems ems	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in	n U.S. 13.	Was Deceden	t of His Cuban	panic Orig	gin? (Speci	fy Yes or No- can, etc.)	-	14. Race - Ame Black, Whit	
36	hours after death with the Maryland turel', or Items 23a or 28a-f show al Exartains the motified at	by Fu	1 Never Married 2 Mar	If Yes, Giv	9		1 ☐ Yes 2 🛭		Specify:				Specify: Whi	ite
21215-0036	hour turel'	q pa	3 Widowed 4 Divorced	Year or Da	ites.	16a Dece	dent's Usual C	Occupat	ion			16h Kir	nd of Business/	/Industry
15	in 72 n "nal Acdic	plet		st grade completed) College (1	4 = 2 5 .)	(Give	kind of work of DO NOT use	done du		t of working	7	100.11		
212	filed within Hygiene. other than "	Completed	12th	College (1	-401 5+)	Pers	onne1_	Spe	ciali	ist		U.S	. Gover	nment
b	9 7 5	BeC	17. Father's Name (First, Middle,						18. Mothe		First, Middle,	Maiden	Sumame)	
Maryland	Ver Ver	2	Angelo Trot						Ros			alia		
Nar	12 sho h and I risma reuma	0 1	19a. Informant's Name/Relation										Town, State, 2	
as a	1 and Health em 27	- 1	John S. Mudd/N	epnew	201	b. Place of Disponentery, cre			1.7	Dat	-		cation - City or	nd 20740 Town, State
nor	ages into the state of the stat		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5							1/28/3	2005		•	ng,Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or of	1	21. Signature of Funeral Service				2. Name and / INES-RI							ing, mary rand
B	Dep Imp	Y 3	Naman A	V. V.	t	H.	LNES-RI 1800 Ne	NAL. w H	DI FU ampsl	UNEKAJ hire	L HOME Ave. S	, IN	C. r Sprin	ng, MD 20904
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cat only one cause on e	aused the d	eath. Do not en	ter the mode o	of dying	, such as	cardiac or i	respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			lerotic								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con:	sequence of):								
	Lxummer	_	Sequentially list conditions,	b. Constal	1 23 2 C 10	sequence of).			_					
	nsit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	*	01 40 4 4011	304001100 01).								
Ć,	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):				· · · · ·	-			
8760,	ate be hysicia the bur			d										
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:									- 15	-	ž.
Вох	eath certific attending pl	lan/l	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 F	etal death 3	⊒Ectopic preg					1	23d. Date of del Month	livery Day Year
0.	it the dea by the a tached f	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time o	of death 5	Other (spec	ify)						,
۵.	res that thigned by		Part II. Other significant condit	ions contributing to de	ath but not	resulting in the t	inderlying cau	se givei	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
ecords,	uires sign ld be	d by									101	Yes 2	□No 3□Pr	robably 4 🛣 Unknown
00	law requas been 2 should	Completed									24a. Was		24b. Were au	utopsy findings available
$\mathbf{\alpha}$	o	mo									autor perfo 1 ☐ Yes	rmed?	death?	completion of cause of
Vital	sicien: Th certificate irector, pag	Bec	25. Was case referred to medic examiner?	al					26. Place	of Death (Check only o			
of V	S S D	10	1X Yes 2 No			2 ☐ ER/Outpatie		Other	4 🗆 1401				6 □Other (Spe	cify)
			27. Manner of Death 1 Manner of Death 5 □ Pend	ilig .	of Injury h, Day Yea	r) 28b. Time of Injury		. Injury Work	?		ld. Describe I	how injur	y occurred	
isio	ten deat tor: the	icat	3 Suicide 6 Could		of Injuny - A	At home, farm, st	M raet factors o		es 2 🗆 l		If Location /	Street an	d Number or Ri	ural Route Number,
Division	o ete i Circ	Certification:	4 Homicide deten	mined 200. Flace buildi	ng, etc. (Sp	ecify)	ieer, ractory, c	JIIICO		20	City or Tov			ardi Fromo Francos,
_	To the Hospitel or At within 24 hours efter or To the Funerel Direct completely filled in by			ing Physician: To the										
	n 24 h	edical	(Check only 2 Medica	Examiner: On the ba and man	asis of exam ner stated.	nination and/or in	nvestigation, in	my opi	inion, deat	th occurred	at the time,	date and	place, and due	e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifi	er					number			29d. Dat	e signed (Mont	h, Day, Year)
	2 ~		> Um	~			D	-15	236			Nov	ember 2	26, 2005
	20		30. Name and address of person Carl Margolis	who completed caus	e of death (Item 23a) (Type ockville	Print) Pike,	Ro	ckvi1	lle, N	Maryla	nd 2	0852	
	Sta	ate	31. Date filed (Month, Day, Yea	r) 32(R	egistrar's Si	ignature /	arke							
	Regist	rar	NOV 2 8	3 2005	gue	15 19								

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Mary	and / Depa		of H	ealth a		ntal Hygi	iene)5	40055
			1. Decedent's Name (First, Middle, Las)					2.	Date of Death Month		Voar	3. Time of Death
	Physici /Medio		Betty Jane Tice						No	vember			1:15 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of	Death		ath Day Year to 25 2005 1: Ac. County of Death Cecil th, Year) 9. Birthplace (St. Country) PA 10g. Citizen of What Country? USA 14. Race - American India Black, White, etc. Specify: White 16b. Kind of Business/Industry Oil Company Maiden Sumame) tar, City or Town, State, Zip Code) Nowing O, MD 219 20c. Location - City or Town, State Kennett Sq., PA Funeral Home, Fing Sun, MD 219 23d. Date of delivery Month Day Disacco use contribute to the cause of the completion of the completi		
			171 Pleasant Grow	re Road			nowi				Ce	cil	
	Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birthday)	If Under 1 Months	Year Days	If Under 2	Min.	Date of Birth (Month, Day,	Year)	Day Year 25 2005 4c. County of Death Cecile arr) 9. Birthplat Country 1928 10d 10d 10d 10d 10d 10d 10d 10	lace (State or Foreign
	Director		168-24-7330		77 Yrs.				Ju	ly 27,	1928		PA
	and *		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation						1	0d. Inside City Limits
	Aanyl sho	5	MD Cecil		Conowing	0							1 □ Yes 2 X No
	28a-	ect	10e. Street and Number		conowing	10f. Zip (Code			10	a Citizen of	What Cour	ntry?
	with the contract of the contr		171 Pleasant Grov	o Pond			918				-		,
	Jeath Tras 2%	by Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			spanic Origi	in? (Specif	y Yes or No-		ce - Americ	an Indian,
S	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No					Puerto Rio	an, etc.)	Bla	ck, White,	etc.
ğ	ral', o	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2,	K) No	Specify:			Speci	^{v.} Whit	e
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28a-f show ha Mudical Exain in meat be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual	Occupa done d	ition uring most o	of working	1	6b. Kind of E	lusiness/Ind	dustry
21	ithin Jen Mar	du	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work DO NOT use	e retired)				210	0	
2	ygier ygier her th		12		Cle	rical	1	40.14.4.4					ny
Ind	be find H	Be	17. Father's Name (First, Middle, Last)								laiden Sumai	710)	
3	d Mer d Mer narke	²	Jeter Carson Burg		401 14 10		(2)			Street			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at any injury or other traumatic.		19a. Informant's Name/Relationship (7										
_	1 and Healt em 2 thar		Sally McGuigan/do 20a. Method of Disposition						e Koa Date			•	21918
Baltimore,	Pages nent of I ant: If its		1 X Burial 2 X Cremation 3 □	nemoval from State	Db. Place of Dispo cemetery, crer							-	
Ħ	permit. Page Department o Important: If any injury or once.		' 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service License		nion Hil			U 1	1-30-	2005	Kennet	t Sq.	, PA
Bal	Depa Impo any ir		21. Signature of Furieral Service Licens		3	Name and	Address	oo o C	R.T.	Foard 1	Funera	l Hom	e, P.A.
			23a. Part I. Enter the disease, or comp	lications that caused the	death. Do not ent					-		, MU	Approximate
			shook, or heart failure. List only of Immediate Cause (Final	one cause on each line.	1 /		1 1		1	oophatory and	J.,		Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	a. Due to (or as a cor	static	-6	do	n	1				
46	Examiner			Due to (or as a cor	isaquarica oi).								
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C									
oʻ	an ar urial-t	EX	resulting in death) Last	Due to (or as a cor	nsequence of):								
3760,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d									
9	teath certifical attending phy I for use as th	Physician/Med	IF FEMALE:										
Вох	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		Ectopic pre	gnancy						*
	e dea the at	SICI	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	of death 5	Other (spe	cify)					Jii(i)	Day 18a1
P.0	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions co	entributing to dooth but no	t reculting in the u	adarbina aa		s in Dark I	· I	22a Did tab	2000 1100 000	tributa ta th	an anuma of death?
S,	signe d be d	by	Part II. Other significant conditions of	manualing to death but no	t resulting in the u	nderlying ca	use give	mmPanti.		1 ☐ Yes	_/		
orc	w raquir baan si should l	ted			-				-				
Records,	e 2 s	Completed								24a. Was an autopsy	, i	prior to cor	psy findings available npletion of cause of
E	(0	CO											2 🗆 No
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of	this ald	To	1 Yes No	1 L Inpatient	2 ER/Outpatier 28b. Time of		1	4 Nurs	sing Home	-		- ' ' '	′)
U	ding After fune	lon	Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	M	Work	ai. ? ′es 2.⊟N		. Describe not	w injury occur	180	
Sic	death.	Ca	3 Suicide 6 Could not be	28e. Place of Injury -	At home farm str			03 2 2.1	-	Location (Stro	eet and Numi	per or Rura	I Route Number
Division	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Sp	oecify)	cot, ractory,	OIIIOO			City or Town,	State)	70, 0, 710,0	, riodio riambor,
	To tha Hospitel or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune		29a. Certifier Certifying Phy	/sician: To the best of my	knowledge, deatl	n occurred a	t the time	e, date and	place, and	due to the car	use(s) and m	anner as st	ated.
	a Ho 124 h 19 Fu letely	Medical	(Check only 2 Medical Examone)	iner: On the basis of examination and manner stated.	mination and/or in	vestigation,	in my op	inion, death	occurred	at the time, da	te and place,	and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c.	License	number		29	d. Date signe	d (Month, I	Day, Year)
			1 Inda	5 M		1	60	176.	8		11/28	105	
			30. Name and address of person who d	ompleted cause of death	(Item 23a) (Type,	Print)		0		0	1		- //
_			M. Jokhadar,	2816.	Main	8t.	1	Cisin	9	Sun1.	MS	219	7//
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature			/					
	Regist	rar	NOV 2 8 2005	Bedien Jo.	100								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death RegcNo. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 25, 2005 Physician 6:15 P M BENNIE TAYLOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES LA PLATA CENTER, GENESIS ELDERCARE LA PLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 12, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1₹M 2□F Months Hours Min. 89 SOUTH CAROLINA 249-18-3579 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at XXYes 2 □ No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 UNITED STATES 756 UNIVERSITY DRIVE Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S.
Agned Forces? 194114 Yes 2 □ No
If Yes, Give 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 24 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR-BATTERY CASTINGS ELECTRIC STORAGE BATTERY CO. 3RD GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 Is marked of: Be ROSE TAYLOR VINCENT WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, RUTH M. TAYLOR / WIFE 756 UNIVERSITY DRIVE, WALDORF, MARYLAND item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of h Importent: If ite any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BEAUFORT NATIONAL CEMETERY DEC. 2, 2005 BEAUFORT, SOUTH CAROLINA * 4 ☐ Donation 5 ☐ Other (Specify) Quature of Funedal Service License 22. Name and Address of Facility

THORNION FUNERAL HOME, P.A., INDIAN HEAD, MARYLAND 20640 John LYDIA C. THURNTON JOHNSON MO0583 RILEY FUNERAL HOME-HAMPION CHAPFL, INC., HAMPION, S.C. 29924 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's unknown /Medical Due to (or as a consequence of): Examiner Bacteremia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 🗆 Other (specify) 4☐ Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by decubitus - Stage 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 0 4 Nursing Home 5 Residence 6 Other (Specify) this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a e Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) Medi and manner stated To the the within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 055455 susse 11-28-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5625 ALLENTOWN ROAD, SUITE #101, CAMP SPRINGS, MD 20746 FATIMA Y. HUSSEIN, MD

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

NOV 2 8 2005

State of Maryland / Department of Health and Mental Hygiefie (1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 27, 2005 GEORGE AUGUST TAYLOR 1:59 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WOODLANDS ASSISTED LIVING BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
APRIL 28,1917

APRIL 28,1917 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Funeral Months 1XM 2□ F Yrs 88 Director 216-10-2797 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or itams 23a or 28a-f shov Examinat must be notified at 1 ☐ Yes 2 X No CENTREVILLE Director **QUEEN ANNE** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21617 USA 260 HIBERNIA ROAD death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 If Yes, Give filed within 72 hours after 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 □ Divorced Year or Dates 1945-1945 WHITE natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, I've Madical 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER PLUMBING -0-12 markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill and Mental H is markad ott Be ELIZABETH ROSE BRIETENBACH GEORGE HOLMES TAYLOR 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8108 PHILADELPHIA ROAD, ROSEDALE, MD 21237 ERNEST A. TAYLOR/ SON itam 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY 12-1-2005 CENTREVILLE, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Lice see 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. any ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-transit Box 68760 Physiclan/Medical as the t IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 0 á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2010 Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED LIVING examiner' Hospital: 1 ☐ Inpatient Other: Jo 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 Pother (Specify, 2 ☐ ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attanding Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainton as success.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 For State Registrar Amended item #5 per fh/wich@ertificate of Death11-29-05/d18eg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0 S 00 1 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sa WICOMICO Age (In yrs. last birthday) Min. 8. Date of Birth (Month, Day, Year) 3/2/1952 9. Birthplace (State or Foreign Country) Maryland 1 M 2 Z Days -56-3765 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Wicomico Maryland Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21849 7296 Jones Hastings Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Important: if item 27 is marked other then "nature!; or itams 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exercise.

Physician

/Medical

Examiner

Funeral Director

Funeral

Director

aska

10a. State

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

₹

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

"oreall, MD

NOV 2 8 2005

Division of Vital Records, P.O. Box 68760,

3	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			220110	эрвену.		Specify:	wnite
o posidino	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	Decedent's U	sual Occup	ation during most of wo	orking 1	6b. Kind of Busi	ness/Industry
Ĺ	Elementary/Secondary (0-12)	College (1-4or 5+)	1	life. DO NO	T use retired	1)	9		
	10	-	Qua	ality (Contro	ol Engine	eer	Wholesa	le Jewelry
	17. Father's Name (First, Middle, Last)						me (First, Middle, M		
	Richard Hall						le Marie E		
	19a. Informant's Name/Relationship (Ty. Roger Lee Truitt/		19b.	. Mailing Addr 7296 J	ones F	and Number or R Hastings	ural Route Number, Rd., Pars	City or Town, St. sonsburg	ate, Zip Code) , MD 21849
	20a. Method of Disposition		Place of	Disposition (f	Vame of	20)	Date 2	0c. Location - Ci	ty or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		bury Ci	,	, I	/26/05	Salisbu	ry, MD
	21. Signature of Funeral South Lio me			22. Name Hol.10 501	and Address Sway E Snow F	ss of Facility Tuneral I Hill Rd.	Home Profe , Salisbur	essional cy, MD 2	Association 1804
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat	h. Dor	not enter the m	ode of dyin	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Matectatio		Corn	.0	Cane	01		Onset and Death
	resulting in death)	Due to (or as a conseq	uence o	of):	- Company	Carre			GYEAVS
	a company of the later								,
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l	cause. Enter Underlying Cause (Disease or injury that initiated events								
	resulting in death) Last	Due to (or as a conseq	uence c	of):					
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Ì	23b. Was decedent pregnant 23	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		3 □Ectopic	nregnancy			23d. Date o	f delivery
	in the past 12 months?	4☐Pregnant at time of d		5 Other				Month	Day Year
1	9 Unknown	9□ Unknown							
	Part II. Other significant conditions con	tributing to death but not res	ulting in	the underlying	g cause give	en in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?
							1 ☐ Yes	2 NO 3[Probably 4 Unknown
							24a. Was an	24h War	e autopsy findings available
			-				autopsy performe	prio dea	r to completion of cause of the
	25. Was case referred to medical examiner?					26. Place of Dea	ath Check only one		
Į.	-		ER/Out	patient 3	DOA Othe	er: 4 🗌 Nursing H	lome 5 🗌 Residen	ce 6 Other (Specify)
	27. Manner of Ceath Natural 5 Pending 2 Accident investigation	28a. D te of Injury (Month, Day Year)	28b. T	ime of ijury M	28c. Injury Work	rat c? Yes 2 ∐No	28d. Describe how	injury occurred	
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, far	m, street, fact	ory, office		28f. Location (Stre City or Town,	et and Number o State)	or Rural Route Number,
	29a. Certifier Check only one) Certifying Phys	ician: To the best of my kno	wledge,	death occurre	ed at the tim	e, date and place pinion, death occu	to, and due to the cau irred at the time, date	se(s) and manne e and place, and	er as stated. due to the cause(s)

DHMH 17 Rev 1/2001

eath (Item 23a) (Type, Print)

32. Registrar's Signature

4. 5	Physic	ian	1 - State Registrar 1. Decedent's Name (First, Middle, L George Washi	ist)						2. Date of De	-300-0	2005	3. Time of Death
	/Medi		4a. Facility Name (If not institution, gi			4h Cih	/ Town or	Location of	of Doath	Novemb		2005 by of Death	10:53 AM
	Examir	ner	Frederick Me				ederi		DIDBAIN			derick	
	Funeral		5. Social Security Number 6. 578-22-2291	Sex 7. a	Age (In yrs. last birtho	Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da JAN 28	th y, Year)	9. Birthpl	ace (State or Foreign
	Director		Usuel Residence of Decedent		83					JAN 28	1922	Frede	erick, MD
	yland		10a. State 10b. County		10c. City, Town o	Location						10	Od. Inside City Limits
	e Mai	ctor	MD Freder	ick	Bruns	vick							1 XYes 2 No
	should be filled within 72 hours after death with the Maryland and Mental Hygiene in Mental Hygiene in Mental Hygiene in Mental Cale of the Francisco of the Francisco of the Cale of State in Medical Examinations in Medical	Funeral Director	10e. Street and Number 605 W. Potomac S	treet		10f. Z	ip Code	716			10g. Citizen of	What Count	ry?
	death	nera	11. Marital Status	12. Was Deceder	nt Ever in U.S.	3. Was Dece			gin? (Spec	cify Yes or No-		ce - Americe	en Indian,
9	after or Ite	/Fui	1 Never Married 2 Married	Armed Force 1 2 Yes 2 [If Yes, Give	s? □No	If Yes, spo		n, Mexican Specify:	i, Puerto F	lican, etc.)		ick, White, e	
ő	hours turel',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates								fy: Whi	
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Baltimore, Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other traumatic event,	2	George Washingto								lickman		
Mar			19a. Informant's Name/Relationship James Michael We								r, City or Town		
5	of Health of Hemory is		20a. Method of Disposition	inier, son	20b. Place of Di				eet,		zick, Ml 20c. Location		
ē	Pages nent of I int: If It		1 ☐ Burial 2 ☑ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		Hagerst				11/26	5/05		stown	
<u>=</u>	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service/Lice			22. Name a	nd Addres	s of Facility	v				
Ω.	20 E E 8		Barbara A. Wi	lliams, O	wner	John 1 100 Pe	r. Wil	lliam ville	s Fui Road	neral H 1. Brun	lome swick,	MD 21	716
8760,	Physician /Medical Examiner physician and physician and the prirat-transit	lical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list on dittors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pului Due to (or a	Ine. MEN IN	pf+ 1	iner	104	,e /11/2	CONTRAL EX	· /	1	Approximate interval Between Onset and Death
24hr.	the death certifi y the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	4□Pregnant 9□Unknown	2 ☐ Fetal death at time of death	3 □Ectopic p 5 □ Other (s)	pregnancy pecify)				23d. Da	te of delivery	/ Day Year
E, F	law requires that las been signed b	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying o	cause give	n in Part I.		23e. Did to	bacco use con	tribute to the	cause of death?
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Sec.	ne law has b	mpie	Chance And	thilure, -	hotty of	gov	2.h. An	vn/		24a. Was a autops	sy	prior to comp	sy findings available pletion of cause of
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0	ding Phys I. After this funeral di	n: To	27. Manner of Death	28a. Date of Ini (Month, D			28c. Injury Work	4 U Nur			ence 6 Oth		
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[(小女人 神文学化 (P軽工)) Division of Vital Records, P.	or Atter de Directo	Certification:	3 Suicide 6 Could not be determined	286. Place of Ir building, 6	njury - At home, farm, etc. (Specify)	street, factor	y, office						Poute Numban
_	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier AC Certifying PI	At hon	t of my knowledge, de of examination and/or	ath occurred	at the time	e, date and	nlace an	d due to the e	2002(2) 22 d m's		runswick,
	the hin 24 the F	Medi		and manner s	stated.				n occurred				
	To vit		29b. Signature and title of certifier	11/1	1 1	290	c. License	7/78	-/	2	9d. Date signe	·	
	intl		30. Name and address of person who	completed cause of	death (Item 22a) (Time	a Print'	15	11 /8	8		11/23	3/200	5
425	10,		Christopher Flem:				Brun	swick	c. MD	21716			
1	Sta		31. Date filed (Month, Day, Year) -	32. R	trar's Signature								
	Registr	:17	11011 0 0	anne Par	-C /5	TIPE SELECT							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] 5 #10e, per f.home, 12/2/05, Certificate of Death E.T., WCHD, No. Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2005 ar 26^{Day} Connie M. Warren 0815 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ XF 64 1/29/1941 Director 217-36-2355 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow itam 27 is marked other than "natural; or items 23a or 28a-1 aho other traumatic event, the Medical Examination must be notified at 1 Yes 2 No Director Worcester Ocean City MD 10e. Street and Number 10027 Keyser Pt. Rd. 10f. Zip Code 10g. Citizen of What Country? 127 Keyser Pt. Rd. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be 99 George Woodrow Warren Myrtle Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health itam 27 i 9905 Mason Rd., Berlin, MD 21811 Dee Whittington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State o E 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. Sunset Memorial Park 11/29/2005 Berlin, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature i Funcial Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Luhale 23a. Part1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subarachnoid Hemorage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to introduce Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 🛛 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Schizophrenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' certificate 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 🛛 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours after To the Funeral Dira ō 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5362 11/29/2005 30. Name ess of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Dr. Berlin MD Barer, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 2 9 2005

			1 - For State Registrar	State of Ma	ryland /	•		t of H			1ental Hy	giene Reg. No. U	05	40061
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	/Medic Examin		4a. Fecility Name (If not institution, give HARTLEY HALL NURS)					Town, or				4c. Co	ounty of Death	
	Funeral Director		5. Social Security Number 6. Sec. 462-01-1149	x 7. Age] M 2	(In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi Month, D. 10/1/1	rth av Year) 911	9. Birth Cou Tex	place (State or Foreign ntry) aS
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	B		30. Name and address of person who co	ompleted cause of de	')			Dr. S	Sarad	Bar	al 2185	1		
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3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and where Color and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 15818 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Inju	ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit of property of the physician/Medical Examiner	To be Completed by Physician/medical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (c b. Due to (c d. 23c. If yes, outc 1 Live bit 4 Pregna 9 Unknot Atrial f. Hospital:	propagation to 2 Equipment	Do not enter it in the understand in the underst	the mode of dyn hema to topic pregnanc ther (specify) erlying cause gw	y ven in Part I. 26. Place of C	23e. Did 24a. What autopering the pering autopering aut	23d. Date No. 1 24b. V. One)	a of deliver the fibute to the sibute to the sibute to the sibute to come leath?	Approximate Interval Between Onset and Death Death Onset and D
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependent of Heelth and Mental Hygiene. Important: If item 23e or 28e-f ahow important: If item 27 is marked other than "natural", or Itama 23e or 28e-f ahow any injurgage ther traumatic avant, Ira Medical Exerting must be notified at ance.	þ	1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🔀	JNo		1 ☐ Yes 27 N			, etc.)	Specify:	k, White, e	WHITE	
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Division of Vital Records,	al or Atte s after de if Diracto id in by th	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of I	njury - At home, etc. (Specify)	larm, sti	eet, factory, offic	6		ocation (Stree ity or Town, S	et and Numbe State)	r or Rural	Route Nur	п <i>ber</i> ,
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis and manner	of examination	lge, deat and/or in	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and di ath occurred at	ue to the caus the time, date	se(s) and man and place, a	ner as sta nd due to	ited. the cause((s)
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	12		TIMOTH	Y F BURNS	MEDICA	OCTU	R	ES-	000	N	DAEWG	GR ?	27,2	+005

State Registrar 31. Date filed (Month, Day, Year) DEC 0 7 2005 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY F BURNS, THE TOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, MARYLAND

State of Maryland / Department of Health and Mental Hygiege For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) LOIS MAE ARMIGER Day Month Year **Physician** 5:00 PM December 8. 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 111 East Fort Avenue Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Aug 24, 19. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 AF 51 220-68-6422 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be excitited at Maryland N/A 1 XYes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 East Fort Avenue 21230 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Certified Medical Assistant Medical Field 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vernon Sidney Armiger Mental Marion Mae Sudbrook it of Health and Menta ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne C. Aro (Sister) 111 East Fort Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If ony injury or Cedar Hill Cemetery 12/12/05 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker ²² MacCul Iy-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Balto., Md. 21230 aguc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Ovavian Carcinomo Physician Metas Ta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed/a 2 No certificate 2 No 1 Tyes ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this nin 24 hours after death.

the Funerel Director; After thi
moletely filled in by the funeral. 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2 10 007930 | T 301 St. Paul Place Baltimere, Ind December uon 10 arson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Feldman, M.D.
Year) 32. Registrar's Signature 1. Marvine 31. Date filed (Month, Day, Year) State DEC 1 3 2005 and the Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1- seemend Item#8 per FH G851 1/23/06 Ceffificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12 Year **Physician** 05 11 12:30a M Ailor Jr. Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Towson Towson 8. Date of Birth 11-4-07 9. Birthplace (State or Foreign (Month, Day, Year) Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number 1 XM 2 ☐ F Days ΜĎ 98 216-01-3764 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 1√ Yes 2 No by Funeral Director Baltimore NA MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Apt 706 21201 U.S.A. llll Park Ave 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City Hall Chauffer 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daisy Hill Edward S. Ailor Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1111 Park Ave Apt 706, Balto, Md 21201 Edward S. Ailor III-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 12/16/05 Arbutus, Md 21. Six ature of Fundal Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner physician and s the burial-transit Records, P.O. Box 68760 the

Funeral

Director

or 28e-f show

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natural

al Hygiene.

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Pages 1

Importent: If item 27 is any injury or other treum

the Medical Examiner must be notified at

death with the Maryland

72 hours after

5-0036

DECEMBER

EDWARD AILOR

Division of Vital

requires that the death certificate be executed use as attending for use as the the ģ has page 2 certificete Physician: this After this funeral To the Hospitel or Attending Pl within 24 hours after death. To the Funarel Diractor: After th completely filled in by the funera

State

Registrar

Certification:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)
DEC 1 3 2005

29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be

1 ☐ Yes 2 😿 No

27. Manner of Death

1 XNatural

2 Accident 3 Suicide

4 Homicide

39a. Certifier (Check only one)

Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3□ DOA

28c. Injury at Work?

1 X. Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

1)43721 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12/12/05

HOSPICE

		1	For State Registrar	State of I	Marylar				lealth a Death	ind Me		giene Rog: No	11115	4006	57
Ph	ysicia		1. Decedent's Name (First, Middle,	Last)							2. Date of De	Da	v Year	3. Time o	f Death
//	Medic	al .		Sondra		ζ.	Ado				Decem		8, 200		0 A ^M
Ex	amin	er	4a. Facility Name (If not institution, 4522 Ambermill		er)				Location of				County of Dea		
Fun	eral	~			Age (In yrs.	last birthday)	If Unde	r 1 Year	ingham If Under 2	24 Hrs.	8. Date of Bir	th			or Foreian
Dire			219-66-8627	1 □ M 2 🔀 F	49	Yrs.	Months	Days	Hours	Min.	(Month, Da April	ay, Year,		thplace (State of country)	si i olongii
D *	HEARS		Usuaf Residence of Decedent 10a, State 10b, County		10c Ci	ty, Town or Lo	antion							-	
Aaryla I eho	la Da	5	Maryland		100.0	.,,	Oation							10d. fnside C	2 No
the the	notif	Director	10e. Street and Number	timore			10f. Z	p Code	Not	ting	ham	10a. Ci	tizen of What C		
C1Z13-UU35 1 within 72 hours after death with the Maryland jiene. r then *natural*, or ttems 23a or 28a-1 ehow	ad la		4522 Ambermi	.ll Road					21236				ted Sta	•	
deat	NO.	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Dece	dent of Hi			ofy Yes or No lican, etc.)		14. Race - Am	encan Indian,	
s after or it.	all l		1 Never Married 3 Marrie	d 1 ☐ Yes 2	₽No				Specify:	, r doito r	iicari, etc./		Black, Whi	te, etc.	
hours line	A EX	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Date	es:	16a Davi	d==4l= 1.1=	-1.0				1		White	
. 13. T.	Special	Completed	(Specify only highest	grade completed)		16a. Dece (Give life.	kind of wi DO NOT i	ork done d ise retired	during most	of workin	g	160. F	and of Business	Vindustry	
d within	1	E	Elementary/Secondary (0-12) 12 Years	Coflege (1-4	or 5+)		Bokke						Home De	not	
Baltimore, Maryland 21213-0035 semit. Peges 1 and 2 should be filed within 72 hours at Depertment of Health and Mental hygiene. mportent: If Itam 27 is marked other then *natural', or	vent,	BeC	17. Father's Name (First, Middle, La	ast)			Donnie	OPCI		r's Name	(First, Middle	, Maider		:poc	
Tarylan 2 should be and Mental 1s marked	atice	2	Gerald H. Not	tingham					Lu	cill	e E. E	rvin			
Aar 2 sho and 1s m	or other traumatic event,		19a. Informant's Name/Relationshi										or Town, State,		
e, N 1 and 1 and Health am 27	hert	-	Mr. Samuel L. A 20a. Method of Disposition	dolfo, Jr.		452 Place of Dispo			.11 Ro	ad]			, Maryl		236
IMOTE, Peges 1 ar nent of Hea	0 0		N⊠Burial 2 ☐ Cremation 3		ite C	cemetery, crei	natory or	other place	1				ocation - City or		
ITIN III. Pe	njury		4 □ Donation 5 □ Other (Special Service Li		Ga				Cem.		2/2005	Ro	ssville	, Maryl	and
Baltimo permit. Pege Depertment Importent: If	eny le) hall	Fill			Duda-	-Ruck	Fune	ral 1	Home o	f Du	ndalk,		
₩ *	1.2.	1	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	sed the deat	th. Do not ent	er the mo	W1Se	g, such as c	ardiac or	ndalk, respiratory a	Mal	ryland	21222 Approximat	te
Physic	cian		tmmediate Cause (Final	niy one cluse on each	A line.	C A .	Ker							Interval Bet Onset and	
/Med	ical		disease or condition resulting in death)	a. Due to (or	as a conseq		(0)							1 gta	47
Exami	. 49		Sequentially list conditions.	b											
P	Sit	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of).									
xecut	ıl-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	mence of):									
cate be executed physicien and						,201100 017.									
OS/ ificate	es the	edlo		0.											
Geath certific e attending p	nse e	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			76						23d. Date of de	livery	
. 0 0	od be	Cla	in the past 12 months? 1 ☐ Yes 2 🗑 No	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	t at time of d		Ectopic p Other (s)						Month	Day	Year
that the de	etach	Phys	9 Unknown												
on a b	peq	2	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the u	nderlying (ause give	in in Part I.				use contribute to		
v requi	should	eted									10	Yes 2	MPNo 3□P	robably 4 Ut	Jnknown
VITAL MECOTO SICION: The law requir certificate has been si	9 2	Completed									24a. Was autop		24b. Were as prior to death?	utopsy findings completion of c	available ause of
	or, page		25. Was case referred to medical				_				1 Yes	2 No	1 Yes	2 □ No	
valcle	=	To Be	examiner?	Hospitaf:	ationt 2	ER/Outpatien	it 3 🗆 D0	Othe			Check only o		6 □Other (Spe		
O E E	-		27. Manner of Death	28a. Date of I		28b. Time of		28c. Injury Work	at		d. Describe I			ciry)	
ath.	e fur	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	tion	Day (Bai)	Injury	м		res 2 N	lo					
DIVISION I or Attending after death. Director: Afte	by t	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place of	fnjury - At he	ome, farm, str	eet, factor	y, office		28	If. Location (S City or Tov	Street ar	d Number or R	ural Route Num	ber,
oltelo rel D	lled ir														
To the Hospitel or within 24 hours afte To the Funerel Dir	completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be caminer: On the basis	s of examina	wledge, death ition and/or in	occurred vestigation	at the tim , in my op	e, date and inion, death	place, an	d due to the	cause(s date and	and manner as place, and due	stated, to the cause(s	i)
To the h within 24	eldmo		29b. Signature and title of certifier	and manner	stated.			c. License					te signed (Mont		
⊢ ≩ ⊢	ថ		b Ut				_		8048	-		(7	8/05	y, / Ga//	
	0	-	30. Name and address of person w	no completed cause of	of death (Iten	n 23a) (Tvpe	-	y , 0	,~ (1			~	(0105		
	i			6 Philade			•	e 304	Bal	timo	re, Ma	ryla	.nd		
	Stat	е	31. Date filed (Month, Day, Year)		strar's Signa	ture									
Re	gistra	ır	DEC 1 9 2005	Bea.	10	Boarde	,								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yeer **Physician** 0320 A M 07 Armstrona December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore City

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. The Johns Horkins Hospital N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 🔀 😾 2 🗆 F 126-58-5835 Yrs. 46 Director 10-17-1959 New York Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No Director NY Browne Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 Rogers Road USA 13865 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: à white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Daniel D. Armstrong Estella E. Cortright 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth end Important: If item 27 is n any injury or other treun QDC6. Liz E. Armstrong 26 Rogers Road Windsor, NY 13865 Baltimore, Laka Flizabeth Armstrong) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State Metro Crematory 12/09/2005 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 Kreun Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Nonsmall cell Heuroendocrine Carcinoma disease or condition resulting in death) OK Month /Medical Due to (or as a consequence of): Examiner Intra abdominal hemmorheige 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed and-tran: that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien a hed for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4 Pregnant at time of death P.O. signed by the ☐Yes 2☐No 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No of Vital Attending Physicien: rector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After Certification: Division 1 MNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospitel within 24 hours a 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December, 07, 2005 Docter Oddegirmenci Medical Kes-000 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) 300 Caten Avenue Baltimore MD 21229 Ordegirmenci 19 San

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

		1 = For State Registrar	State of M	laryland / Dep	artment of He	ealth and Me	•	9	40069
Phy	/sicia	1. Decedent's Name (First, Middle, Las		0			2. Date of Death Month D	ay Year	3. Time of Death
2-6	ledica	WIIIIam II.	Alger,				December		6:10 P M
Exa	amine				4b. City, Town, or L	Location of Death	4	c. County of Death	h
		Greater Baltimo: 5. Social Security Number 6. S		l Center ge (In yrs. last birthday)		WSON If Under 24 Hrs.	Data of Righ	Baltimon	
Fune Direc			(XM 2□ F	85 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Year ug. 19, 1	920 Vir	nplace (State or Foreign untry) ginia
100		Usuel Residence of Decedent				f1	ug. 17, 1	720 VII	gilla
arylan	1	10a. State 10b. County N/A		10c. City, Town or Lo					10d. Inside City Limits
M er M	9	5		Daitime					14 Yes 2 No
with ti	8 2	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Cou	untry?
eath	Interior	1436 Morling Aven	12. Was Decedent	Ever in IIS 13	21211		du Voc es No	USA 14. Race - Amer	iona ladia
Ther d	N. O.	1 Never Married 2 Married	Armed Forces	? No	Was Decedent of His If Yes, specify Cuban,	, Mexican, Puerto Ri	ican, etc.)	Black, White	
036 036 ours a	EXP	3 ☐ Widowed 4 ☐ Divorced	1 ₩ Yes 2 ☐ If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite
21215-0036 d within 72 hours after death with the Maryland giene.	158	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 1 17. Father's Name (First, Middle, Last)	ducation	16a. Dece	dent's Usual Occupati kind of work done du	tion	16b. ł	Kind of Business/I	ndustry
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nd 2121 a filed within the Hygiene.		11 17. Father's Name (First, Middle, Last)		ETE	ectrician	19. Mothor's Name /	First, Middle, Maide	ndepende:	nt
and d be shall list of o	2	William M. Alge					ce Howland		
Maryland Maryland od 2 should be file tith and Mental Hy 27 is marked oth	E P	William M. Alge		19b. Maili	ng Address (Street an				in Code)
Alger, Maryland and 2 should be fil alth and Mental H	othar traumatic event, the Mr	Margaret Alger	Wife						land 21211
		20a. Method of Disposition		20b. Place of Dispo		Da	-	ocation - City or T	
Pages	5	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		St. Abra	aham's Cem	etery 12/1	Becl	kleysvil	le, MD
Baltimore, permit. Pages 1 a Department of Hee Important: if them	eny in	21. Signature of Funeral Service Licen	Vens) Bi	2. Name and Address 1rgee—Hens: 531 Falls	of Facility s-Seitz Fi	uneral Hor	me, Inc.	21211
	Ä	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cause	d the death. Do not ent	ter the mode of dying,	such as cardiac or	respiratory arrest,	11 y 1ana	Approximate Interval Between
Physic	ian	Immediate Cause (Final disease or condition			hak	4			Onset and Death
/Medi		resulting in death)	Due to for as	se consequence of: deffe	770-07	0-	,		
Examir	2 3	Sequentially list conditions,	b	deffi	ell C	ally			
79	1151	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (of as	a consequel ce of):					
sxecul and	in in in	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
P.O. Box 68760, nat the death certificate be executed by the attending physicien and classified control of the purity for the purity transition.	in a		d						
68 ifficate g phy	3		. u.						
Box 6	as as	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deliv	very
Vision of Vital Records, P.O. Box 68 Attending Physician: The taw requires that the death certified robath. The taw requires that the death certificate has been signed by the attending probability of the contribution pages 2 should be discreted from a second pages.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	4☐ Pregnant a		Other (specify)			Month	Day Year
P.O. that the ded by the	Dh.	9 Unknown							
ds, F	3 1	Part II. Other significant conditions of	ontributing to death t	but not resulting in the u	nderlying cause given • £	in Part I.			the cause of death?
cord w require been si		Hypertense	200	outer			1 ☐ Yes 2	No 3 Pro	bably 4 Unknown
Hecker has the	4 8	Trypercerval	NYC				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
al F	g G						1 Yes 2 → No	death? 1 ☐ Yes	2 No
on of Vital Reding Physician: The information in Control of the chilogenesis certificate in the control of the chilogenesis control of the chi			Hospital:		! Other	26. Place of Death (
Of Phy or this	E C		28a. Date of Inju	urv 28b. Time of	IL 30 DOX	4 Nursing Home	5 Residence d. Describe how inju		fy)
ion nding tth.		Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	<i>y Year)</i> Injury		s 2 No		,,	
Division of Vital Records, to Attending Physician: The taw requires the death. Director: After this certificate has been signed to buy the functor of the formand of considerate.	6	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, farm, str tc. (Specify)	eet, factory, office	28	f. Location (Street ar	nd Number or Rur	al Route Number,
Div tal or safte		5	bullaring, e	ic. (Specify)			City or Town, State	3)	
DIVISIC To the Hospital or Attent within 24 hours after deatt To the Funeral Director:	pietery in	one)	ysician: To the best niner: On the basis of and manner st	of my knowledge, death of examination and/or in- ated.	h occurred at the time, vestigation, in my opin	, date and place, and nion, death occurred	d due to the cause(s at the time, date an) and manner as s d place, and due t	stated. to the cause(s)
To the To	3	29b. Signature and title of certifier			29c. License n	number	29d. Da	ate signed (Month,	Day, Year)
	7	Mathere	ne l	isade	50 HOO	54970	12/0	06/05	
10	/	30. Name and address of person who o	completed cause of c	death (Item 23a) (Type,	Print)	v /	1000	. مدد	0 0
10	C	31. Date filed (Month, Day, Year)	Sade D	D 20 E	· Timonia	unkel A	Log Ilmi	mumm	1 21093
Rec	State istra	50010	2005	come 13.	GOODE				

			For State Registrar	State of	Maryland / I		artment o			d Mental H	ygiene	5 1	+0070
¥	Physici	an	1. Decedent's Name (First, Middle,					,		2. Date of D	eath Day	Yeer	3. Time of Death
E	/Medic	al	Fortunate 4a. Facility Name (If not institution,	B. Andr			4b. City, Tow	vn, or Loc	cation of D	Decemb		1005	03:00 a M
74		g de	Oak Crest				Baltir				Bal:	timore	9
48.	Funeral Director	å	218-09-5806	6. Sex 1 □ M 2 □ F	Age (In yrs. last bii	rthday) Yrs.	If Under 1 You Months Da		Under 24 I Hours N		Sirth (Day, Year) 26 1918	Con	place (State or Foreign Intry) 11and
	ylend		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	cation						10d. Inside City Limits
	Ba-f el	ctor	Md. Baltim	ore	Baltim	nore							1 ☐ Yes 2X No
	within 72 hours after death with the Marylend ene. then "natural", or items 23s or 28s-f ehow ha Madical Exarcinar russi Le nutilled at	Funeral Director	10e. Street and Number 8800 Walther B	lvd. #2005			10f. Zip Cod 2123				10g. Citizen o	of What Cou US	*
	r death	ınera	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. \	Was Decedent f Yes, specify (of Hispa Cuban, N	anic Origin's Mexican, Pi	? (Specify Yes or Nuerto Rican, etc.)		ace - Amer	ican Indian,
36	urs afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Wildowed 4 ☐ Divorced	d 1 X Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 X ☐		Specify:	,,		<i>™</i> Whit	
2-0	72 hou		15. Decedent's (Specify only highest		16a	(Give	lent's Usual Ockind of work do	one durin	n na most of	working	16b. Kind of	Business/l	ndustry
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylen of Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinat numbers to nutilise at	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+) Pa	life. I	rn Make	etired)	•		Clothi	ng Ma	nufacture
nd	at Hyginal Hyginal Allocher	BeC	17. Father's Name (First, Middle, L.		<u> </u>			18.		Name (First, Midd	le, Maiden Sum		
ryla	hould to d Ment market matic	ဥ	Alphonse And	reone	101	Mailie	a Address (St		Clau	dina Tar	antela	- 0 7	
	and 2 s alth an 27 ls er trau		Mr. Thomas Andre		130					timore, N			p Code)
ore	it of He if of He if Item or oth		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation	3 □Removal from St	ate cemete	ry, cren	sition (Name o	place)		Date	20c. Location		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 to eny injury or other tra once.	1	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		New Ca		dral Ce	ddress of	f Facility	-12-05	Baltim		Md.
ä	Depa Impo eny i		14/7	1			Ruck 1050	Tows	son Fi k Rd.	uneral Ho Towson,	me, Inc Md. 212	04	
新			23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	on elications that cau nly one cause on eac	sed the death. Do		er the mode of	dying, s	uch as care	diac or respiratory	arrest,	ase	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequence		netive	01	um	orang	pisa	216	
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	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	of):							
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68760,	ficate by physical to the b	edicai		d									
Вох	that the death certifii led by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		h 2 Fetal death		Ectopic pregna					Date of deliver	rery Day Year
o <u>i</u>	t the de by the a ached f	hysic	1 □Yes 2 □ No 9 □ Unknown	4∐Pregnar 9☐Unknow	nt at time of death	5 [_	Other (specify	v)				, onti	Day Toal
ds, P	S	Ď	Part II. Other significant condition	s contributing to dea	th but not resulting i	n the ur	nderlying cause	e given in	n Part I.		tobacco use co		the cause of death?
Vital Records,	ie law require has been sig ge 2 should t	Completed								24a. Wa		. Were aut	opsy findings available
a R										per 1 Yes	opsy formed? 2 M2 No	death? 1 ☐ Yes	ompletion of cause of 2 No
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	vatient 2 ER/Ou	utoatien	t 3 DOA	Other		Death (Check only g Home 5 1 e	-	ther (Special	(6,1)
n of	ing Ph After th uneral		27. Manner of Death 1	28a. Date of (Month,	Injury 28b.	Time of Injury	28c. l	Injury at Work?			how injury occ		'''
Division	Attending r death. ector: After by the fune	Certification	2 Accident investiga 3 Suicide 6 Could no	ot be	Injury - At home, fa , etc. (Specify)	arm, str			2 🗆 No	28f. Location	(Street and Nur	nber or Rur	al Route Number.
á	urs after or ral Diru) [4 Tromicide								own, State)		
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the b xaminer: On the bas and manne	is of examination an	e, death nd/or inv	occurred at the restigation, in n	ne time, d ny opinio	date and ploon, death o	ace, and due to the courred at the time	e cause(s) and (), date and place	manner as : e, and due t	stated. to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	X A	N		29c. Lic	ense nu	8 g	5	29d. Date sign	ned (Month,	Day, Year)
	3+1		30. Name and adocess of person w	the cause	official (Item 23a)	Пур	Parkv	, lle	٥	MD 7	1230	4	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3	657	istrar's Signature	1	seels.						

			For	State of Maryland	d / Department		-	_	1.0071
			1 - State Registrar		Certificate	e of Death	Reg. N	40.	40071
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las	ice Ap.H	WP I I I		12 - 0	Day Year	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give	. 1	1	Fown, or Location of Death		Bathmo	
	Funeral Director		5. Social Security Number 6. S	Hospital Cen ex 7. Age (In yrs. le		1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	thplace (State or Foreign ountry)
	Maryland f show	ō	10a. State 10b. County		, Town or Location	. 4.0			10d. Inside City Limits
	r 28e-	Director	10e. Street and Number	soke	101. Zip		10g. (Citizen of What Co	
	23a c	rai D	1 Horebell Cou	apt Apt A1		1236		15 0	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show any fourty or other traumatic event, Ite Medical Exaction relate builtied at ance.	by Funerai	11. Maritaf Status 1 □ Never Married 25 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 17€Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Deced If Yes, spec	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert Solo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
200	72 hou nature	sted	15. Decedent's Ec	ducation	16a. Decedent's Usua	l Occupation	16b.	Kind of Business/	/Industry
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	I Hygir other	Be Co	17. Father's Name (First, Middle, Last)		rkoduct		ne (First, Middle, Maid	en Surname)	company
ylar	Menta Menta Merked Marked	To	ECRIPAL ARTH	ub		Mary	Wells		
Maryland	d 2 sh th and th sm traum		19a. Informant's Name/Relationship (1		19b. Mailing Address	(Street and Number of Ru	ral Route Number, City	or Town, State, 2	Zip Code)
	of Heal	- 1	20a. Method of Disposition		ace of Disposition (Name ametery, crematory or ot	ne of her place)	Date 20c.	Location - City or	Town, State
Baltimore,	Pages tment of tant: If It jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y) Gara	lison Forest	VA Cervetony Dec	.15,2005 Du	ings m	ills, Maryland
Bal	permit Depar Impor eny In	S	21. Signafure of Funeral Service, Licen	RUALS	22. Name and 8800 H	Address of Facility ZV	Parkville	Morylano	121234
			23a. Partil. Enter the disease, or com- shock, or healt failure. List only	plications that caused the death one cause on each line.	. Do not enter the mode	of dying, such as cardiac	or respiratory arrest,	July 1	Approximate Interval Between
1.36	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Acute H	Γ				Onset and Death
	Examiner			Due to (or as a consequ	rence or):				
	sit s	iner	Sequentiafly list conditions, I ary leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consequ	ience of):				
Ž.	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):				
8760,		cai		_ d					
89 x	death certifica e attending ph id for use as th	/Mec	fF FEMALE:	23c. ff yes, outcome of pregnar	ncv			004 0-4-4-4	r.
.O. Box	ires thet the death certifica signed by the attending ph d be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pre			23d. Date of del Month	Day Year
rds, P	The law requires thet the ste has been signed by the bage 2 should be detache		Part ff. Other significant conditions of	ontributing to death but not resu	Iting in the underlying ca	use given in Part f.		o use contribute to 2 □ No 3 □ Pr	o the cause of death?
Vital Record	law requir as been si 2 should	Completed					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
al B	icien: The law certificate has rector, page 2 :						performed?	death?	2 No
Ξ	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospitaf: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 DO	Othor	ath (Check only one) lome 5 Residence	6 DOthor (Sac	-61
n of	nding Physicien: th. ; After this certifica § funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending			Bc. Injury at Work?	28d. Describe how in		Cny)
Division	Attending r death. ector; After by the funer	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e and Discontification Ather	М	1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or D	and Courts Marsh
Ω	Itel or A irs after rel Dire	Certification:	4 Homicide determined	building, etc. (Specify,			City or Town, Sta	a <i>t</i> e)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death occurred a ion and/or investigation,	at the time, date and place in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as ind place, and due	s stated. to the cause(s)
)	To t With To t	Σ	29b. Signature and title of certifier Muche	lle Hist		License number 78		Date signed (Monti	h. Day, Year)
	541		30. Name and address of person who			ware Drive	An Illian	, NI 71	7 2.7
	Sta		31. Date filed (Month, Day, Year) 1	3 2 Registrar's Signat	ture de la lace	10	NACCITATION	5, 1-10, 21	<u>-01</u>

DHMH 17 Rev 1/2001

Arthur, Robert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 18 per fh 850 12-15-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 4:200 DECEMBER Z005 GLORIA B. ARMSTEAD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 307 BURNIE ANNE KALEIGH 1<D JLEN HRUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 M 2 XF Yrs. Director 212-34-7782 70 3-18-1935 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehow r then "naturel", or Iteme 23s or 28a-f ehov the Wedical Examinar must be motified at 1X Yes 2 □ No Director MD. ANNE ARUNDEL GLEN BURNIE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 RALEIGH RD. 21060 USA Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should ba filad within 72 hours afternent of Health and Mental Hygiene. Int: If Item 27 le markad other then "naturel", or Ite ☐Yes 2XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: BLACK 3 ☐ Widowed 4 ₹ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12 SELF EMPLOYED DAYCARE PROVIDER item 27 le markad othe other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDITH JOHNSON P RUFUS N. SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM L. GLENN JR(SON) 307 RALEIGH RD. GLEN BURNIE, MARYLAND 21060 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = ŏ Department o Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 12-15-2005 GLEN BURNIE, MARYLAND 21. Signature of Funeral Service Licensee HARRY REESE 22. Name and Address of Facility WM. REESE AND SONS MORTUARY, P.A. eese 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOPULMONARY ARREST SECONDARY **Physician** /Medical Examiner RHEUMATOID ARTHRITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed FAILURE 10 Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 2 🗆 No 1 🗌 Yes 2 🗆 Accident investigation Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

Signature

Box 68760

P.0.

nysician

5

and manner stated.

2005

who completed cause of death (Item 23a) (Type, Print)

32. egistrar's Signature

Par policy

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

042041

29d. Date signed (Month, Day, Year) 12/12/05

Ritchie Huy, Brooklyn Park, MD 21225

				For State Registrar	• •	aryland / Dep		Health and N	lental Hy		05 4	0073
		Physici /Medic		1. Decedent's Name (First, Middle, Last Raymond Franci	,	n	Val		2. Date of De Month 12	Day 06	Year 2005	3. Time of Death 4:40 PM
		Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. C	ounty of Death	<u></u>
				Broadmead Retirem 5. Social Security Number 6. Se		nity e (In yrs. last birthda	Baltimo		8. Date of Bir		1timore	
	L	Funeral Director			XM 2□F	91 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 04-17-	1914	Penns	lace (State or Foreign stry) sylvania
		ryland how		10a. State 10b. County		10c. City, Town or				-	11	0d. Inside City Limits
		88-18	ector	MD Baltimor	e 	Baltimore						1 ☐ Yes 2X☐ No
		death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number 1504 Dundee Court			10f. Zip Code 21014			U.S.A	n of What Coun	try?
(980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ② I If Yes, Give X Year or Dates:	Ever in U.S. 13	Was Decedent of High Yes, specify Cub. 1 ☐ Yes 2 ☑ No		pecify Yes or No Rican, etc.)		. Race - Americ Black, White, o pecify: Whi	etc.
wdon:h	Baltimore, Maryland 21215-0036	within 72 hu sne. than "natu se Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12	cation le <i>completed)</i> College (1-4or 5	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	nation during most of work d)	king .	Sheet	of Business/Inc	
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7	ylar	ould be Menta wrked	To B	Francis Ackerma				Gertrude				
10	, Mar	and 2 sh alth and 127 is m er traum		19a. Informant's Name/Relationship (T) Janice Regester		19b. Mai P O E	ling Address (Street SOX 206, C	and Number or Aut Oburn, Vi	al Route Numb rginia	er, City or 1 2423		Code)
3/0/05	ore,	ges 1 at of He if item or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F			position (Name of ematory or other place		Date		tion - City or To	
9	İtim	artmen ortant: injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furrial Arvice Ucens			of Faith 22. Name and Addre)-2005 L	altim	ore, Ma	ryland
7	B	Depar Impor any ir		Holdo	>				Belair	Rd.,	Balto.	, MD 21206
				231. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused ne cause on each lin	the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	8760,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a	a consequence of):						
3	687	e ys	edlcal		d							
XXX	O. Box	atter for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		230	d. Date of deliver Month	ry Day Year
大のう	S, P.	res that the d igned by the be detached	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the	underlying cause giv	ren in Part I.				e cause of death?
£3	cord	w requir been si should	leted	CAPA				-	-	Yes 2 124		ably 4 Unknown
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3	Division	ttending I death. ctor: After y the funer	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ No				
RA	Divi	al or At s after o if Direct od in by	Certification;	4 Homicide determined	28e. Place of Inju	ury - At home, farm, s c. (Specify)	treet, factory, office		28t. Location (S City or Tox	Street and N vn, State)	lumber or Rural	Route Number,
		To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical (29a. Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	of my knowledge, dea examination and/or ited.	ath occurred at the tin	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) an date and pl	d manner as sta ace, and due to	ited. the cause(s)
		To the within To the comp	Me	29b. Signature and title of certifier Barbara	Carron	U, M.	29c. Licens	38395			igned (Month, D	
		12		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type		/ VINR	'K R	7) /	7/6/2 DCKF	MID
	•	Sta		31. Date filed (Month, Day, Year)		ar's Signature	1	y 0/\	1 / / !	/ (UNC	y virily
	DH	Registr MH 17 Rev 1/2	<i>:</i>	DEC 1 3 2	005	on the	foort			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kene 14 07 PM DEC 05 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, ST , AGNES give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Mgnth, Day, 9. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 245-42-9213 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "natural", or itama 23a or 28e-f ehow the Medical Examinar must be notified at 1 XYes 2 ☐ No Director Maryland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "ne any njury or other traumatic event, it a Mutile once. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 🔊 e) ,21223 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location · City or Town, State 20a. Method of Disposition cemetery, crematory or other piece) 12 1 X Burial 2 ☐ Cremation 3 Removal from State 2005 Mem. Par * 4 ☐ Donation 5 ☐ Other (Specify) butus 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility W. North Ave. Rus e Bairo 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Physician DAYS /Medical Due to (or as a consequence of): **Examiner** EUMON DAY Sequentially list conditions, Due to (or as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-transit Exami the attending physician and the check that the shed for use as the burial-transparent resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown Ö 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 3 Probably 4 Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy performe certificate ! 1 Yes 2 No Vital Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of After this funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred or Attending Injury Division 1 Natural 5 Pending death. 1 🗀 Yes 2 🗌 No 2 Accident investigation hours after death filled in by the 6 Could not be determined 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HW 2005 DEC 05 P17604 30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print) 5/10, FATTAH 906 BALTIMORE SATON AVE 21229 MO 32. Registrar's Signature 31. Date fited (Month, Day, Year) State Registrar

ORIGINAL

IC HARD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Year 6 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner lage uture (are Jak Ke If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 154M 20 F Months 218-46-8940 Director Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at 1 Nes 2 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? a 12. Was Decedent Ever in U,S. Armed Forces?,
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mantal Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Hack ξ 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) tandy ma 12th in merked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be nent of Health end Mental ames 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beeto, arrie Cartes 3510 W md, 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremetion 3 □ Removal from State 6 12-13-05 zear Cem. 4 □ Dorretion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3405 W. kert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Beeto, nd, 21229 Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Physician/Medical Examiner law requires that the death certificete be executed use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last end been signed by the attending physicien should be deteched for use es the bune Division of Vital Records, P.O. Box 68760 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown To Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 🗆 Yes 2 X40 1 ☐ Yes 2 No Physician: director, 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 ER/Outpatient 3 DOA neral Director: After this filled in by the funeral di 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred To the Hospital or Attending Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) un 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Wortern mid BACT. AMBACHEW 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar DEC 1 3 2005

DHMH 16 Rev 6/95

			1 - State Registrar	State of Marylar	nd / Depa		lealth and N	nental Hyg	•	40076
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death
	Physici /Medic			Florrie E	louise	Brow	n	Month 12	Day Year 4 2005	4:30 a ^M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			3630 Oakmont A	venue		Ba1	to		N/A	
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director		212-30-4438	72	Yrs.			6-13-1	933	S.C.
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	daryli eho	5								1X Yes 2 No
	28a-1	ect	Md N/	A	Balto	10f. Zip Code			Og. Citizen of What Co	
	with o	Funeral Director	3630 Oakmont A	Tonuo		2121	_	'		outiny:
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			ecity Yes or No-	U S A	erican Indian
(0	r Her	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give	1		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
03	el', o	by	3	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify: I	31ack
2-0	be filed within 72 hours after deeth with the Maryland tal Hygiene d other than "naturel" or Items 23a or 28a-1 ehow event, the Medical Evanting must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation	una	16b. Kind of Business	Industry Unk
7	thin it	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of work d)	9		
2	ygier th	ပ္	llth grade	N/A	Fact	ory Work				
<u>n</u>	tal H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		,	
<u>₹</u>	ould Men Marke Marke	2	Charlie Zimmerma					e Sumter		
Maryland 21215-0036	and and		19a. Informant's Name/Relationship (Marian Wilson -		19b. Maili				City or Town, State, 2 Md 21207	Zip Code)
	1 and Health		20a. Method of Disposition						20c. Location - City or	Town State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat must be notified at any injury or other treumatic event, the Medical Examinat must be notified at any injury.		1XXBurial 2 ☐ Cremation 3 ☐	Inemoval Hom State		osition (Name of matory or other place				
듩	it. P.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer				rk 12-10		andallstow West	n, Md
Ba	permi Deperimental		M	I Wet		430		•	Balto, md	21215
			23a. Parl1. Enter the disease, or com shock, or hear failure. List only	plications that caused the dear	th. Do not ent					Approximate
	Physician		Immediate Cause (Final	one cause on each line.			- 1			Interval Between Onset and Death
)	/Medical		disease or condition resulting in death)	a. Due to (or as a consec	Mg cs	us kee	of feel	ure		luk
	Examiner			D		to lun	of fact			1 mout
		ner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):	1	 -			1 Volume
X	nd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Car	cenomo	Color	n Meto	Xale		& moult
,092	ate be executed hysician end he burial-transit		resulting in death) Last	Due to (or as a consec	queńce of).					
876	ate b	dicai		d						
x 68	entific ding p	Me	IF FEMALE:	00- 14						
Вох	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn. 1 Live birth 2 Feta	aldeath 3	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
P.O.	the de	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time of c 9 ☐ Unknown	death 5	Other (specify)				,
	thet t ed by detai		Part If. Other significant conditions c	ontributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	w requires thet the death certifica been signed by the attending ph should be detached for use as th	d by						1 ☐ Ye	s 20⊠No 3 Pr	obably 4 Unknown
00	w req	Completed						24a. Was a	24h Wara au	tangu findings available
Re	sicien: The law s certificete has b lirector, page 2 s	E C						autops: perform	ned? death?	topsy findings available completion of cause of
a	ifficet or, pa	ပိ	25. Was case referred to medical						1	2 No
<u> </u>	raicle s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3 DOA Oth		h (Check only on	nce 6 □Other (Spe	
ō	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c, Injun	y at	28d. Describe ho		опу)
<u>.</u>	nding F ath. r: After e funera	atio	1 Natural 5 Pending 2 Accident investigation		Injury	M 1	k? Yes 2 □ No			
Division	Atte octo by th	ill Co	3 Suicide 6 Could not be determined	286. Place of Injury - At n	iome, farm, str	eet, factory, office		28f. Location (Str	eet and Number or Ru	ıral Route Number,
Ō	tel or	Certification;	-	building, etc. (Specia				City or Town		
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the			ysician: To the best of my known on the basis of examina	owledge, deat	h occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner as	stated.
	the F the F the F	Medical	01107	and manner stated.						
	To Vit	2	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monti	h, Day, Year)
	./		J.			123	344		16/08	
	'n		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print)	ALD MO			
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	4 FEN	1 Rd 131	TIN MO	2/2	27	
	Sta Registr	_	DFC 1 3 200	5 Pagistrar's Signa	Son	Ale D				

			For State Registrar		artment of Health and artificate of Death	Mental Hygie	2000 40077
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Allyne F. Bell		2. Date of Death Month December	Day Year 3. Time-of Death
	Examin	- 8	4a. Facility Name (<i>If not institution, give streed</i> Alice Manor Nursing		4b. City, Town, or Location of Dea Baltimore	th	4c. County of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 1 \square M	7. Age (In yrs. last birthday 81 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Ye	9. Birthplace (State or Foreign Country) 1924 Maryland
	show	or	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	ocation Baltimore		10d. Inside City Limits ★\\ Yes 2 \(\) No
	with the had or 28a-i	Direct	10e. Street and Number 2095 Rockrose Avenu		10f. Zip Code 21211	10g.	Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event, It a Medical Examinar must be restified at once.	y Funeral Director	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2√2√No If Yes, Give	Was Decedent of Hispanic Origin? (stif Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 名文No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	nin 72 hours in "natural" Medical Ex	Completed by	15. Decedent's Educati (Specify only highest grade oc Elementary/Secondary (0-12)	mpleted) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	erking 16b	b. Kind of Business/Industry
nd 212	be filed with stal Hygiene id other the event, the	Be Com	10th 17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	,
Maryland	should to nd Ment markad umatic	2	Martin Mulligan 19a, Informant's Name/Relationship (Type,	Print) 19b. Mai	Annie	e Davis Mul	
	and 2 sealth ar n 27 la		Donald Bell	Son 1414	W. 37th Street	Baltimor	e, Maryland 21211
nore	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	JVai IIUIII State	position (Name of ematory or other place)		Location - City or Town, State
Baltimore,	permit. Page Department Important: If any injury or		21. Signatural Funeral Service Licensee	Metro Ci	22. Name and Address of Facility Burgee—Henss—Seitz 3631 Falls Road I	z Funeral H	tonsville, Maryland
	Sales -		23a Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final	ons that caused the death. Do not enable on each line.	nter the mode of dying, such as cardia	c or respiratory arrest,	Approximate
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	she caraior	ascular	Disase
	1.550	iner	5-acusotia y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	tic Cardior Disease Broart		
38760,	ficate be executed physician and s the burial-transit	ai Examiner	Cattles (Disease of Injury that initiated events c	Due to (or as a consequence of	Measy		
.O. Box 687	death certi e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S, D	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
Vital Record		Completed				24a. Was an autopsy performed	
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	oital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Othor .	ath (Check only one) Home 5 🗆 Residence	e 6 (Tother /Specify)
ion of	ding h. After fune	ertification; T	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	
Division	s after de	Certific	3 Suicide 6 Could not be determined	8e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one)	an: To the best of my knowledge, dea On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 7 To the Comple	Σ	29b. Signature and title of certifier	MD.	29c. License number D47405		Date signed (Month, Day, Year)
1	0/2		30. Name and address of person who comp	200	Print) Law St.	Baltim	me MD2/20/
	Sta Regist		31. Date filed (Month Pay, Year) 3 200	32 filograph Signature			

		-	For State Registrar	State of Maryland	d / Depa	artment rtificate	of H	ealth a	ınd M		Reg. No.	05	40078
	Physicia	_	1. Decedent's Name (First, Middle, Last) Eugenia Teresa Boh	ıle						2. Date of De Month 12-8-2	Day	Year	3. Time of Death 8:00 A M
Н	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, 1	Town, or	Location o	f Death		4c.	County of Dea	
			7700 Locust Wood R				ever				A	nne Ar	
	Funeral Director		212-05-1067	7. Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 3-1-19	iy, Year)	9. Bir Co MD	thplace (State or Foreign ountry)
	Maryland f show led at	or	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		, Town or Lo	ocation							10d. Inside City Limits 1 Tyes 25 No
	28a-	rec	10e. Street and Number		CVCIII	10f. Zip	Code				10g. Citi:	zen of What C	ountry?
	3a ou	Ö	7700 Locust Wood R	Road		2	2114	4			U.S.	A	
36	be filed within 72 hours after death with the Maryland Ital Hyglene. ad other than "natural", or Items 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral Director		12. Was Decedent Ever in U.S Armed Forceş? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	i i	Was Deced If Yes, spec			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whi Specify:	
Maryland 21215-0036	hour tural	edt	15. Decedent's Educ		16a. Dece	dent's Usua	I Occupa	ation			16b. Kir	nd of Business	/Industry
5	in 72	piet	(Specify only highest grade	College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	luring most)	of workii	ng			
212	i with	Completed	Elementary/Secondary (0-12)	College (1-401 3+)	Opera	ator					Pho	ne Com	pany
פַ	e filed of the vent,	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)	
ılar	2 should be and Mental is marked eumatic ev	5	John Wesley Lloyd					Fr	ance	s Euger	nia M	lacKebe	e
ar	s 1 and 2 should f Health and Men item 27 is marke other treumatic	3)	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ng Address	(Street a	and Numbe	r or Rura	l Route Numb	er, City o	Town, State,	Zip Code)
	2 = 2 t		Mr. John F. Bohle							; Seven		D 2114	
ore	of Heal	1 9	20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □R	emoval from State	lace of Dispo emetery, crea							cation - City or	Town, State
Ë	Pag ment tent: jury		' 4 ☐ Donation 5 ☐ Other (Specify)							3-2005		n Burn	
Baltimore,	permit. Pages Department of t Importent: If it eny injury or o		21. Signature of Funeral Service License	65- Male 11101	364 1		nd A	ve SW	; G1	en Buri	nie,	MD 210	
Į	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death ne cause on each line. Due to (o as a consequence)	d the					4			Approximate Interval Between Onset and Death
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		ē	Sequentially list conditions,	Due to (or as a consequ									
	uted Id ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
760,	icate be executed physician and s the burial-transit	cai Ex	resulting in death) Last	Due to (or as a consequent	uence of):								
68											1		
P.O. Box	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	⊒Ectopic pro □ Other (sp					2	23d. Date of de Month	elivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not rese	alting in the u	anderlying ca	ause give	en in Part I.	_		tobacco u Yes 2 [to the cause of death?
Vital Records,		Completed								24a. Was auto perfe 1 Yes	psy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	La - Nach			045	-	of Death	Check only	one)		
d	Physicien: rthis certificanal director, is	은	1 Yes 22 No	lospital: 1 Inpatient 2				4 🗀 140				3 □Other (Spe	ecify)
Ä	ding P h. After i funera	on:	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 2	8c. Injun Worl	/at k? Yes 2 ☐		28d. Describe	now injur	y occurred	
Division	ten Jeat tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st			163 20		28f. Location (City or To			Rural Route Number,
L)	To the Hospitel or Attend within 24 hours after death To the Funeral Director; completely filled in by the i	edical Ce		sician: To the best of my kno ner: On the basis of examina and manner stated.									
	o the	Me	29b. Signature and title of certifier					e number					th, Day, Year)
	F 3 F ŏ) OOO 10.	bett	0		161	>>L	14		12	15/2.	_
	5		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type	, Print)	77	/ (]	7		-	, ,, ,	
	13			citerata	300	40500	Kal	Sr.	He	N Bur	wie	and	21061
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	. A							
	Regist	rar	nec 1 3	71111	130	THE SE	-						

			1 - For State Registrar	State	of Maryla		artment rtificate				fental Hy	giene Reg. No.	005	40079
			Decedent's Name (First, Middle,	Last)							2. Date of De			3. Time of Death
	Physici		Eleanor	Marie			Bitne	r			Decembe	Day r 5	2005	1:30 P M
1	/Medio Examir		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location				County of Dea	
			3300 Benson Av	enue Ant	301		Hale	thor	. n. o			D.	. 1	-
	Funeral			6. Sex		. last birthday)			If Under	24 Hrs.	8. Date of Birt	th	altimor	
	Director		214-14-7463	1□M 2∏ F	8.	3 Yrs.	Months	Days	Hours	Min.	Dec.4,	v. Year)	2 0	thplace (State or Foreign ountry)
			Usual Residence of Decedent				1			1	200.1,			<u></u>
	/ian/		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Man	ğ	MD Balti	nore	Hal.	ethorpe								1 ☐ Yes 2 ☑ No
	the 28s	9	10e. Street and Number				10f. Zip	Code				10a Citiz	zen of What C	ountry?
	With Page 1	by Funeral Director	3300 Benson Avei	nue Ant30	1			227						
	eath 3e 23	era	11. Marital Status		edent Ever in t	118 13			spania Ori	inin2 (Co	anifu Van ar Na	- 1	4. Race - Ame	rises to disc
	iten d	5	1 ☐ Never Married 2 ☐ Marrie	Armed F	orces?	10.	If Yes, spec	fy Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, Whi	
9	rs at	à	3 ☑ Widowed 4 □ Divorced	If Yes, G Year or D	ive		1□ Yes 2	X No	Specify:				Specify: W	hite
ဗု	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow te Medical Examiner must be notified at	ed	15. Decedent's			16a Dece	dent's Usua	I Occupa	ition			1Ch Kin	nd of Business	O-dust-
5	n 72	Completed	(Specify only highest	grade completed)		(Give	kind of wor	k done d	uring mos	t of work	ing	IQD. KIII	id of business	rindustry
21215-0036	with Bne.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		emake					0	TT	
2	Hygi Hygi nt,		17. Father's Name (First, Middle, L	act)		11011	emake.	L .	19 Moth	arte Nam	e (First, Middle,		Home	
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Maryland	2 st 2 st ie n reun	U.	19a. Informant's Name/Relationsh								a <i>l R</i> oute <i>Numb</i> e	•		, ,
4	end ealth m 27	n i	Mr Michael E.	Schmidt					d Ave		Haletho			
9	of H of H if ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	Bemoval from	1	Place of Dispo cemetery, crei	isition (Nam natory or oti	ie of her place	9)		Date	20c. Loc	ation - City or	Town, State
Ξ	Peg ment: ant: ury c		4 ☐ Donation 5 ☐ Other (Sp.		Du.	laney V	alley	Mem	. I	Dec.9	2005	Timo	nium,M	d
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m	89E 29		Mark a.	Vanuere	MO	13571	Secon	d Av	re SW	; G1	en Burn	ie, N	MD 2106	1
П			23a. Part1. Enter the disease, or o	omplications that										Approximate Interval Between
	Physician		23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death											
7	/Medical		resulting in death)	a. Due to	(or as a conse	quence of):	icy	10/2	010	14	Mari	21		
	Examiner				14	4/22/	1	D 10	7.1	0				
		e	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conse	guence of):		010						
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ō	ath. r: Af	atic	1 Matural 5 Pending 2 Accident investiga		,, , , , , , , ,	,,	М		es 2 🗆 I	No				
Division of Vital Records,	ar de ecto by th	Certification;	3 Suicide 6 Could no 4 Homicide determin	art 289. Place	of Injury - At h	nome, farm, str	eet, factory,	office					Number or Ru	iral Route Number,
	s after or selection or selecti	Ser	,	Dullo	ing, etc. (Speci	(y)					City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours atterdeath. To the Funeris later death. To the Funeris Lifector. After this certificate has been signed by the attending complately filled in by the funeral director, page 2 should be deteched for use as		29a. Certifier 1 Certifying	Physician: To the	best of my kn	owiedge, death	occurred a	t the time	e, date an	d place,	and due to the c	ause(s) a	and manner as	stated.
	n 24 he Fi	edical	one)	Laminer. On the D	asis of examination of the states.	ation and/or inv	estigation, i	in my opi	inion, deal	th occurr	ed at the time, d	late and p	place, and due	to the cause(s)
	To t To tl	ž	29b. Signature analytitle of certifier	RID				License			2		signed (Monti	
)			> Keet	Ar	4		1	> 31	132	2		12	-16/0	5
	V.		39 Name and address of person w	no completed caus	se of death (Ite	m 23a) (Tyne	Print)							
	1/		PADEED	GARG 1	un	716 M	MDE	n	CHO	1et	(N; (ATO	NSVICE	E, Mg 21228
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Sign		1							, - 0
	Registr		DEC 1:	3 2005	But a car is	de la	certi	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes or Free Print Index (Print Index (Pr

			1 - For State Registrar	State of Marylan		epartment of H Certificate of L			2005 g. No.	40080	
			Decedent's Name (First, Middle, Last	st)			700177	2. Date of Death	1	3. Time of Death	_
	Physici /Medic		Everard 1	Briscoe				Decem		12:15	}
	Examin		4a. Facility Name (If not institution, give	0 0 1	1 .	4b. City, Town, or	Location of Death		4c. County of		
_			5. Social Security Number 6. S	+ HSSISTEC		finks	sburg If Under 24 Hrs.	9 Date of Birth		roll	
	Funeral Director			©M 2□F 81	Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sep. 19	,1924	Birthplace (State or Foreig Country) Maryland	n
	D		Usual Residence of Decedent						,		_
	show	ž	10a. State 10b. County			or Location				10d. Inside City Limits 1 ☐ YesX2X No	
	the M	ecto	MD Baltimo	ore	кет	10f. Zip Code		10	g. Citizen of Wha		_
	death with the Maryland ime 23a or 28a-f show count be pullified at	ā	112 Glyndon Dr				136	10	U.S	•	
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S.	13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race -	American Indian,	
0000	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic avant, the Madical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married XX XX Widowed 4 ☐ Divorced	XXYes 2 □ No It Yes, Give Year or Dates: Kore		1 ☐ Yes XXNo	Specify:	riicari, etc.)	Specify:	white, etc. White	
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Mar	12 sh h and 7 la m traum		19a. Informant's Name/Relationship (2224	1	Mailing Address (Street a					
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Saltimor	Peges ment of tant: If it jury or o		1 ☐ Burial XX ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Met		Crematory	Inc. 12	2/10/05	Ba1ti	more, MD	
Dall	Depart Import any Inj		21. Signature Funeral Service Lice	mu						Chape1P.A. Mills,MD211	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	0 50	elerski			/	Approximate Interval Between Onset and Death	
	Examiner	er	Sequentially list conditions,	b. Due to for as a consequ	uence of	2					
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Į.	thet the ed by detect	Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in t	he underlying cause give	en in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?	
Space	requires thet een signed b hould be dete							1 ☐ Ye	s 2 2 NO 3	☐ Probably 4 ☐ Unknow	n
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	ding After fune		27. Man r of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Tir Inji	ury Work	yat ⟨? Yes 2 □No	28d. Describe ho	w injury occurred		
DIVISION	5 ± 5 ⊆	Certification:	3 Suicide 6 Could not be determined		ome, farn y)	n, street, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,	
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	To the within 2. To the complet	Me	29b. Signature and little of certified	06/-		29c. License	number	29	d. Date signed (i	Month, Day, Year)	
•	/		30. Name and address of person who	completed cause of death (Item	n 23a) (T	Vpe, Print)	5872	, De	comb	9 2003	
	6		ACOV BOB 31. Date filed (Month, Day, Year)	mp 25 1	14	in Streets	esté	· far		21136	
	Sta Regista			32. Registrar's Signa	A.	fort					

			1 - For State Registrar	State of Maryla	-	artmen rtificate				ene (5 4	800	2
	Physici	an	1. Decedent's Name (First, Middle, Las Dixie R.	craig					2. Date of Death Month December		2005	3. Time of 6:30	
	/Medic Examir	al	4a. Facility Name (If not institution, give Genesis Eldercare	street and number)	ne			ocation of Deat		4c. Count	y of Death	<u></u>	Ам
192	Funeral Director		212 20 4423		s. last birthday) 84 Yrs.	If Under Months		If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, March 03		9. Birthp Coun	ace (State o. try)	r Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	ocation					10	Od. Inside Cit	ly Limits
	e Man	ctor	Maryland Anne /	Arundel			Pasa	dena				1 🗌 Yes	2 ∑ No
	with th	Funeral Director	10e. Street and Number			10f. Zip			10	g. Citizen of		try?	
	death me 23	erai	268 North Ferry	12. Was Decedent Ever in	U.S. 13.	Was Deced		1122 panic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Ra	USA ce - Americ	an Indian,	
36	or ite	y Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, spec			to Rican, etc.)	Speci	ack, White, o	ite	
21215-0036	within 72 hours after death with the Maryland ene. then "naturei", or iteme 23a or 28a-f ehow fra Madical Examilier; wat be multied at	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece				1	6b. Kind of E			
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121	filed wi Hygien ther th		5 17. Father's Name (First, Middle, Last)			Cook	1	9 Mother's Na	me (First, Middle, M	Nursin		e	
and	buld be f Mental I arked of atic ever	To Be	Radford Ric				'	Maxie	Sween		me)		
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	1 and Health em 27 ther tr		Algie R. Craig Ji 20a. Method of Disposition				- Carlotte Committee		Rd., Pas	adena,			
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	/Medical		disease or condition resulting in death)	a									
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	onted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	34231103 31.).				NZ G	455			
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P.O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 montbs? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[∃Ectopic pr ∃ Other (sp					ate of delive	,	/ear
	ള മ		Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	inderlying c	ause given	in Part I.	23e. Did tob	acco use cor			eath?
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Vital		BeC	25. Was case referred to medical examiner?	m-3			- 2	26. Place of De	1 ☐ Yes 2 ath Check only one		1 Yes	2□ No	
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on	ding h	tion:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 2	8c. Injury a Work? 1 ☐ Ye	at es 2∐No	28d. Describe hor	v injury occu	rred		
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, sti cify)				28f. Location (Str. City or Town,	eet and Num State)	ber or Rura	Route Numi	ber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complately filled in by the fu	edical Co	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examona)	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the time , in my opir	, date and place	a, and due to the ca arred at the time, da	use(s) and m	nanner as st , and due to	ated. the cause(s))
	within To the comple	Me	29b. Signature and title of certifier			290	c. License r	number	29	d. Date signi	ed (Month, l	Day, Year)	
١,		,	/ SAMI	lade	My	7	21	776	D	Econ	BEX	12,	7005
	0//		30. Name and address of person who	completed cause of death (It	em 23a) (Type, M <i>y</i>) 3	Print)	S.	MANC	Diver s	r. B	AUT	Mo	3
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	E)					2(4	han .

Amend item#26, per Verbal, C850, 12/13/05 TT State of Maryland 7 Department of Health and Mental Hygiene 0.5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 28/2005 **Physician** Charles Edward Coleman, Sr. 8:17 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) 9.7 / 01 / 1930 Wash., 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **⅓**M 2 ☐ F Director 578-38-4773 75 Usual Residence of Decedent 10a State 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show The Medical Examinational be notified at 10d. Inside City Limits Prince George's MD Temple Hills Director 1X Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4005 Leisure Drive 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard L. Coleman Annie B. Galloway Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $4005~{
m Leisure}~{
m Drive}$ of Health an Mazie A., Coleman - Wife Templo Hills, MI 20748 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. Burial 2 □ Cremation 3 □ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/02/2005 Suitland, MD 22. Name and Address of Facility 3831 Ga., Ave., Latney's Funeral Home Wash., DC 20011 Ann. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fpart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner burial-transit certificate be executed Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Renal Insufficency 1 Yes 2 No 3 Probably 4 Unknown Complet Perpherial Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ★R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and Mile of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo13231 11/30/2005 nama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern Maryjana HOSPITCU 32. Segistrar's Signature 31. Date filed (Month State A Allen

Registrar

			1 - For State Registrar	State of Maryl		artment <i>rtificate</i>			nd Menta		ene 2.005	40084
	Physici		1. Decedent's Name (First, Middle, Last Paul D. Cart						Mo	te of Death onth	Day Ye 2005	ar 3. Time of Death 10:39 A M
	/Medic Examin		4a. Facility Name (If not institution, give Southern Marylan	·		4b. City, T		Location of E		<u> </u>	4c. County of D	
	Funeral Director		5. Social Security Number 6. Se 246 36 5372 Usual Residence of Decedent	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hours	Min. (Mo	te of Birth onth, Day, 1	Year) 9.	Birthplace (State or Foreign Country) orth Carolina
	Maryland	tor	10a. State 10b. County Maryland Prince G		.city, Town or Lo Capitol		nts,					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	i Director	10e. Street and Number 1521 Shamrock A	VA		10f. Zip (20743			g. Citizen of What	•
36	urs after death ai', or itema 2 maniner mu	by Funerai	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? NOYes 2 No if Yes, Give Year or Dates:		Was Decede	ent of His fy Cubar		n? (Specify Ye Puerto Rican,	es or No- etc.)		tates mencan Indian, /hite, etc. White
Maryland 21215-0036	within 72 hou ane. than "nature	Completed	15. Decedent's Edu (Specify only highest grad		(Give	DO NOT use	done d retired)	urina most of	f working	16	6b. Kind of Busine	ss/Industry
land 2	uld be filed vidental Hygieriked other itic event, It	To Be Co	17. Father's Name (First, Middle, Last) John Carter		Ca	rpente	r		Name (First,		Self Empaiden Sumame)	ployed
, Mary	and 2 shores alth and he 27 is manes		19a. Informant's Name/Relationship (T) Shirley Carter (W	IFE)	152	l Sham	rock				City or Town, Stat Lights, MI	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28e-f ehow any injury or other treumatic event, the Madical Exacities must be notified at any injury or other treumatic event, the Madical Exacities must be notified at ange.		20a. Method of Disposition 1 \(\) Burial 2 \(\) Cremation 3 \(\) F 4 \(\) Donation 5 \(\) Other (Specify) 21. Signature of Funeral Service License	Removal from State	b. Place of Dispo cemetery, cre akemont	Cemet Name and	ery Addres	Dec 9,	Lee Fur	_I neral	Davidson Home, Ir Inton, MI	ville, MD
	Physician /Medical Examiner		23a Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the cone cause on each line.	leath. Do not en							Approximate Interval Between Onset and Death
8760,		ical Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as a con Due to (or as a con								
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the ettending physicien and paga 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pre □ Other (spe			_		23d. Date of Month	delivery Day Year
	w requires that been signed by should be deta	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying ca	use give	n in Part I.	23		cco use contribute	to the cause of death? Probably 4 Unknown
Division of Vital Records,	: Tha law requ cate has been , pega 2 should	Completed							_	a. Was an autopsy performs Yes 22	ed? death	
<u>≅</u>	sician: Th cartificate rector, peg	o Be	25. Was case referred to medical examiner?	lospital:			Othe		Death (Chec			
ion of	To the Hospital or Attending Physician: Tha within 24 burs site death. To the Funerel Director: After this cartificate ht completely filled in by the funeral director, paga	-	1 Yes 2 No 27. Manner of Death 1 Natural 2 Apoident investigation	28a. Date of Injury (Month, Day Yea.	2 ER/Outpatier 28b. Time o		c. Injury Work	at ? es 2 □ No	28d. De		ce 6 Other (S	рөсіfу)
Divis	Ital or Attendins efter death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, sti ecify)	eet, factory,	office		28f. Loi Cit	cation (Stre y or Town,	et and Number or State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	ledicai	(Check drily 2	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation, i	n my op	inion, death o	place, and due occurred at th	e time, date	e and place, and c	lue to the cause(s)
)	With	Σ	29b. Signature and title of certifier				License	639		290	d. Date signed (Mo	onth, Day, Year)
<	1	-	30. Name and address of person who co			Print)			IVD	2070	F	
) Sta Registr		Jacques Zephiri 31. Date filed (Month, Day, Year) DFC 1 3	32. Registrar's Si	1 Surrat			CTINEO	on, PiD	2073	2	

			State of Maryland / Departmen	nt of Health and M te of Death	lental Hygie	2005	40085
			Registrar CETIIICat 1. Decedent's Name (First, Middle, Last)	e or Dearn	Reg. 2. Date of Death	No.	
	Physici	ian	G		Month	Day Year	3. Time of Death
No.	/Medi		John Malcolm Coulson		December		2:14 p ^M
1.	Examir	ner		, Town, or Location of Death		4c. County of Death	
			Greater Baltimore Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	Towson or 1 Year If Under 24 Hrs.	O Data of Birth	Balti	
€ .	Funeral Director		212.30-4571 10 M 20 F 79 Yrs. Months		8. Date of Birth (Month, Day, Ye	ar) Col	place (State or Foreign
	-		Usual Residence of Decedent		June 1,1	120 Dait	imore, MD
	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
5	a-1-e	ctor	MD Baltimore Time	nium			1 ☐ Yes 2 No
	ith the Marylar or 28a-f ehow	Director		p Code	10g.	Citizen of What Cou	intry?
	23a		III E. Padonia Road.	21093		USA	
=	after dea or iteme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece Armed Forces? 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes	4.		Specify: 1, 1	12 1
000	within 72 hours after death with the Maryland ene. then "natural", or teme 23a or 28a-f ehow he Madical Examinar must be motified at	De De		10	1	W	nite
750	in 72	Completed	(Specify only highest grade completed) (Give kind of wo	ork done during most of worki	ing	. Kind of Business/Ir	ndustry
C 27	with iene. ther	E	Elementary/Secondary (0-12) College (1-4or 5+) SaleSmi		R	20.1.	inalian
<u>a</u>	Hyg other	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	ten Sumame)	applies
S F	lid be lental ked ic ev	To B	Robert Paris Coulson	Mag. F	lanes 1	tash	
ary	shou and A ma uma	-		s (Street and umber Rura	al Route Number, Ci	ty or Town, State, Zi	o Code)
S. Σ.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If them 27 is marked other then "natural; or iteme 23s or 28s-1 ehos eny injury or other traumatic event, the Madical Examinal must be notified at once.		Michael S. Coulson-Son 8721 Val	lleu field Po	T. Timon	ium, Mi	21093
e C	of He		20a. Method of Disposition 1	me of cother place)		Location - City or T	
	permit. Page Department o Important: If eny Injury or once.		4 Donation 5 Other (Specify)	lom. Gardens 12	1-15-05 T	imonium	n mo
alti	permit. Departimporti		21. Signature of Funeral Service Licensee 22. Name ar	nd Address of Facility	Timon	ium mo	21093
	20559		Pencelly O. Sayrotry PEACEFI	nd Address of Facility R.J. 325 YOCK R.J. UL ALT GRN ATT)	IES FUNERU	TU + CREMA	HIONCENTER
£			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	de of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Firmal disease or condition UROSEPSIS				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	LAAITING		Sequentially list conditions, b. UTI				
w	sit sit	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
4	ecut and I-tran	Examiner	Cause (Disease or higher) that initiated events resulting in death) Last C. PARKINSONS Due to (or as a consequence of):				
8760,	cate be executed physicien and the burial-transit		Substitution (or as a consequence or).				
387	phy the	dical	d				
×	Attending Physicien: The law requires that the death certific deeth. sctor: After this certificete has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decoded program 23c. If yes, outcome of pregnancy			224 Date of dally	
Вох	that the death cer ed by the attendir detached for use	clar	in the past 12 months?			23d. Date of deliv Month	ery Day Year
o.	at the d by the tached	lysi	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (sp				
Division of Vital Records, P.O.	s that ned b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did tobaco	o use contribute to t	he cause of death?
rds	quires n signi uld be		CVA		1 🗆 Yes	2₽No 3□Prol	ably 4 Unknown
8	law requir as been si 2 should	Completed			24a. Was an	24b. Were auto	posy findings available
æ	The lay te has age 2	mo			autopsy performe <u>d</u>	/ death?	ppsy findings available impletion of cause of
ā	ysicien: The l is certificete ha director, page	BeC	25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 L No
>	ysici is cer direc	To B	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DC	Othor	me 5 Residence	6 □Other /Specie	50)
0	ding Ph h. After th funeral	L:u	27. Manner of Death 28a. Date of Injury 28b. Time of 2	1	28d. Describe how in		91
io	eth. or: Af	atio	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
<u>×</u>	l or Attend after deetl Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	y, office	28f. Location (Street City or Town, St	and Number or Rura	al Route Number,
٥	itel or irs afte ral Dir iled in l					,	
	To the Hospitel or Attenwihin 24 hours after deet To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) (Check only one) (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	at the time, date and place, a , in my opinion, death occurr	and due to the gause ed at the time, date :	(s) and manner us s and place, and due to	tateu. o the cause(s)
	within 2 To the comple	Med	and market stated.	c. License number		Date signed (Month,	
	C>F0		A though a land	to a Ella ar) 12	111/05	,,
	ox1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00399 10	12	111103	
	2		KATHERINE ASADI DIO 20 E. TIM	onium Rd #	209 Tim	mium M	1 21092
Esp.	Sta		31. Date filed (Month, Day, Year) 32. Regisfrar's Signature	AP .	1	11010	, :-
	Registi	rar .	DEU I A 4003 DECOME TO COMM	4.7			

			1 - For State of Mar	ryland / Departme	nt of Health and Mate of Death	•	2000 4000	6
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)	nter 46. Cit	y, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Dec	ath A
	Funeral Director		218-22-6944 1 M 201F 8	(In yrs. last birthday) If Und Month: Yrs. 10c. City, Town or Location	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Yea	919 Georgia	
	with the Maryla s or 28a-f show be notified at	Director	Maryland Baltimore 100. Street and Number	Baltime	Dre Tip Code	10g. (10d. Inside City L 12 Yes 2 Citizen of What Country?	
036	within 72 hours after death with the Maryland ene. than 'netural', or Items 23e or 28e-1 show te Madical Exercites must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ev Armed Forces? 1 Yes 2 No No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
121215-0036	filed within 72 ho Hygiene. Ithar than "netur ant, It e Madical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT	vork done during most of worki use retired) Tenance	Per	. Kind of Business/Industry Ansylvania Railra	oad
Maryland	d 2 should be fi h and Mental F 7 Is markad ot traumatic ever	To Be	17. Father's Name (First, Middle, Last) JUNY WaterS 19a. Informant's Na re/Relationship (Type, Print) Broth	19b. Mailing Addre	ss (St eet and Number or Rura	e (First, Middle, Maid e Ve al Route Number, Cit	smith	
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28a-f show any injury or other traumatic event. It e Marical Examiner must be notified at once.		20a. Method of Disposition 1 Maurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	20b. Place of Disposition (No cemetery, crematory or Holly Hills	and of other place) Cometery and Address Socility	2005 M Funera	Location - City or Town, State Alle River, M. Home, P.A.	d,
	Physician /Medical		23a. Parti. Enter the disease, or complications that caused it shock or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)	N .		or respiratory arrest,	Approximate Interval Batweet Onset and Deat	
8760,	cate be executed physician and sthe burial-transi	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	consequence of):				
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transitian.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3 Ectopic			23d. Date of delivery Month Day Year	r
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but Chronic Ole Coctain Dolorney Discuse	not resulting in the underlying	cause given in Part I.		o use contribute to the cause of death	
Vital Rec	ician: The law certificate has t rector, page 2 s	Be Completed	Director 25. Was case referred to medical examiner?		26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 1 (Check only one)		ilable e of
of	ding h. Afte fune	၉	1 Yes 2 10 Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day)	2 ER/Outpatient 3 D 28b. Time of Injury M		me 5 ☐ Residence 28d. Describe how in		
Division	- a a	al Certification;	4 Homicide building, etc. 29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death occurre	d at the time, date and place, a	City or Town, Sta	(s) and manner as stated	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Madicel Examiner: On the basis of e and manner state 29b. Signature and title of certifier The world was a state of certifier	xamination and/or investigations and a second secon	n, in my opinion, death occurre 9c. License number	ed at the time, date a	Date signed (Month, Day, Year)	_
2.0	3 Sta		30 Name and address of person who completed cause of dea drume 1 7310 2 to use 31. Date filed (Month, Danielan 1 2 2005. Register	ie Heftway \$5	08 alen Bring	Maryland	21061	
:	Registr			A STATE OF S				

		•	For State Registrar	State of M	Marylan	-	artment of F rtificate of		and Me	ental Hy	giene. Reg. No.	2005	400	87
1	Physici	an	1. Decedent's Name (First, Midd	fle, Last)			-		1	2. Date of De Month	aath Day		3. Time of D	eath
	/Medic	al	Marie Anna 4a. Facility Name (If not institution			r	4b. City, Town, o	v Location o	of Death	12	10	County of Dea	74 4:90	>ttm
	Examin	er	CC 111'	quare Ho	559,1	last birthday)	R656	If Under	16	8. Date of Bi	B	0-1 +1 9. Bin	m 6 f	e Foreian
	Funeral Director		214-12-4565	1□ M 2XF	85	Yrs.	Months Days	Hours	Min	(Month, Da 10/23/	av Yearl	Co	ryland	. o. o.g.
	and **		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City	y. Town or Lo	ocation						10d. Inside City	Limits
$\vec{\sigma}$	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 le marked other then "natural", or Items 23a or 28a-f show or other traumatic event, Ite Madical Examinations in titled at	Funeral Director	Maryland Balt,	•	Es	sex	10f. Zip Code				10a Chia	en of What Co	1 □ Yes 2	
5	3a or	בוֹם		110			21221					S. A.	ountry :	
2	ermu	nera	110 Essex Aven	12. Was Decede Armed Force	int Ever in U.	.S. 13.	Was Decedent of H	lispanic Orig	gin? (Spec	ify Yes or No		4. Race - Ame Black, Whit		
USE (MONT)	72 hours after death w "natural", or Items 23a	þ	1 ☐ Never Married 2 ☐ Ma 3 💢 Widowed 4 ☐ Divorce	rned 1 Tyes 2)	₹) No		1 ☐ Yes 2 X No					Specify:	White	
S & 215-C	within 72 hou ene. then "natural he Medical E	Completed		est grade completed) College (1-4c	or 5+)	(Give	dent's Usual Occup a kind of work done DO NOT use retire	during most	t of working	g	16b. Kir	nd of Business	Industry	
	filed with Hygiene. other ther	Con	12 17. Father's Name (First, Middle	(act)		Homen	aker	10 Motho	orla Nama	(First, Middle		Home		
RIHO Maryland	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, the Market	o Be		_				Anr				su <i>m</i> ame) Schmaus		
ary I	should be and Mental marked o	To	George Willia 19a. Informant's Name/Relation			19b. Maili	ing Address (Street							
1_	and 2 ealth a m 27 le		Lenore R. Davi	S	The Control of		- 3B Ric	h Way				_	d 21050	
Pomme	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tra anca.		20a. Method of Disposition 1 □ Burial 2 □ Cremation		ite C	emetery, cre	osition (Name of matory or other pla		12/	15		cation - City or		
Time of the second	permit. Pag Department Important: I eny injury o		4 □ Donation 5 □ Other (Sa		Heart of .		286 286			alk, Ma	ryland	_
	Depril		Xulore!	mone		Ī	2. Name and Addre Bruzdzins 1407 Old 1	ki Fur Faster	neral rn Ave	Home enue	PA Essex	k. Marv	land 212	221
	· · · · · · · · · · · · · · · · · · ·		27a. Part1. Enter the disease, o shock, or heart failure. Lis	or commications that cause on each	sed the death							<u> </u>	Approximate Interval Between	een
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Va. Hey	Latie	Fail	in						Onset and De	h
	Examiner			Due to (or	as a conseq	uence of): Mef	as fan.						la non	the
	B ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):							1	.//
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Au	ng (me.	7						(o mm	the
8760,	sician and burial-trans		,	Due 10 (01	asa conseq	derice or,								
9	ifficate ig phys as the	ledical		0.										
O. Box	Physicien: The law requires thet the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcor 1□Live birth 4□Pregnan 9□ Unknown	n 2 ☐ Feta t at time of d	I déath 3[⊒Ectopic pregnanc ⊒ Other (specify) _	у			2	3d. Date of de Month	ivery Day Ye	ear .
٠ <u>.</u>	es thet tl igned by be detac	by Ph	Part II. Other significant conditions	tions contributing to deat	h but not res	ulting in the u	underlying cause giv	en in Part I.		23e. Did	tobacco us	se contribute to	the cause of dea	ath?
ords	* requires been sign should be	ted t								1,20	Yes 2]No 3∏P	obably 4 Un	nknown
Division of Vital Records, P.O.	The law ate has by	Completed								24a. Was auto perf		24b. Were as prior to death?	utopsy findings av completion of cau	vailable use of
/ita	iicien: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	11			104		of Death	(Check only	one)			
of	g Phys er this o	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of I		28b. Time of	III 3LI DOA			e 5 Res 8d. Describe		Other (Spe	cify)	
io	Attending I r death. actor: After by the funer	atlo	Z /tooloom	tigation	Day rear)	Injury		Yes 2 □	No					
Divis	el or Att safter de l Directo d in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. Place of	Injury - At he etc. (Specif	ome, farm, st	reet, factory, office		21		(Street and wn, State)		ural Route Numb	θ/,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical (29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physicien: To the be al Exeminer: On the basi and manner	s of examina	owledge, dear ation and/or in	th occurred at the travestigation, in my o	me, date an opinion, dea	id place, ar	nd due to the d at the time	cause(s) , date and	and manner a place, and due	s stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certif	ier /	1	20	29c. Licens		- 1		29d. Date	signed (Mont	h, Day, Year)	
	, _	7	/ Clh C	Wheley	W/	B	02	-435	56		Dece	aber 1	2,2005	
6	7/1	2	30. Name and address of perso	n who completed couse of	1 0	0 0 Type		0 40		on o	Q_	1+: N	10 COMI) 9 122
9	Sta	ate	31. Date filed (Month, Day, Yea		istrar's Signa		DAIL	11 29	wy	UVI	DO	1111	01911	
	Registi		DEC	1 3 2005	99	Lo	frank a							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			iene 0 0	5	40088
			1. Decedent's Name (First, Middle,	,				2. Date of Deat	h		3. Time of Death
	Physici /Medic		Phillip George	Darden				Month Dec.	Day Y	ear	1709 PM
	Examin		4a. Facility Name (If not institution, g	give street and number)	4b. City, Town, o	r Location of Death		4c. County of	Death	
			2106 Morgan Cou	rt		Edgewo	bod		Harfo	rd	
	Funeral		Social Security Number 6	. Sex 7. A 1 □ XM 2 □ F	ge (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	. Birthpl:	ace (State or Foreign
	Director		230-68-5237 Usual Residence of Decedent		55 Yrs.			Aug. 2,	1950 V	<u>irgi</u>	
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	Mary Ff sh	ţo	Maryland Harf	ord	Edgewoo	od.					1 ☐ Yes 2X No
	or 28g	irec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of Wha	at Count	ry?
	72 hours efter death with the Maryland naturel', or iteme 23a or 28e-f show disal Examinar must be notified at	Funeral Director	2106 Morgan Co	urt		21040)		USA		
	r dea	ıner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race -	America White, e	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give		1 ☐ Yes 2 ☐XNo	Specify:	1 110411, 010.7	Specify:		
Ö	hours turel	d be	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	160 Dec	danis Haral Car	-4!				
5.	in 72 in na	piet	(Specify only highest	grade completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of work d)	ing	16b. Kind of Busir	ness/Ind	ustry
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Baltimore,	ges 1 t of H if ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition <i>(Name of</i> matory or other plac	ce)	Date	20c. Location - Cit	y or Tov	vn, State
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	ly one cause on each	~ ^		-100				Approximate Interval Between Onset and Death
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Вох	death certifics e attending ph d for use as th	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	1		23d. Date o Month		y Day Year
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<u>α</u>	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significent conditions	contributing to death	but not resulting in the u	underlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the	cause of death?
Records,	quires n sign		20	road.	disease	_>		1 □ Ye	s 2 🛣 No 3[] Proba	bly 4 □Unknown
000	aw requir is been si 2 should	Completed						24a. Was ar		e autops	sy findings available
	The te ha	mo						autopsy perform	ried? prio	r to com th?	pletion of cause of
Vital	sicien: certifica rector, p	BeC	25. Was case referred to medical examiner?				26. Place of Death			105 2	No.
of V	S S	10 6	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing Hor	me 5 Reside	nce 6 Other	Specify)	727753
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_	Hospital 14 hours a Funeral I	O	29a. Certifier 1 ☐ Certifying	Physician: To the bes	t of my knowledge, deal	th occurred at the tir	ne date and place :	and due to the ca	usa(s) and mann	ar ac cta	tad
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	To the Hospital within 24 hours a To the Funeral I completely filled	Ň	29b. Signature and title of certifier	//		29c. Licens	** - A	1	d. Date signed (A		
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	5		Name and addres of perion with	to complete a cause of	death (Item 23a) (Ty, e	Print)	4206 1 NVE B	1 11	1		
			31. Date filed (Month, Day, Year)	32 Rase	trar's Signature	DAIDIKO	y yre g	YLTO M	1 212	22	
	Sta Registr		1 1 1	3 2005	A. S.	Coaste					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item I per meo 850 12-23-05 vt. State of Maryland / Department of Health and Mental Hygiene 55 40089 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year JAMAAL DAMON TALIB TALIB DAMON 9 December 2005 0055 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A University Hospital **Baltimore** 8. Date of Birth (Month, Day, Year) 6-1-1984 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1√2 M 2 □ F Months 214-25-8566 MARYLAND 21 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 32 N. BERNICE AVE. USA Pages 1 end 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene. Int: If Item 27 ie merked other than "natural", or Items 23. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: W Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: BLACK Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-HOUSEKEEPING HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JEROME DAMON MARY D. SCALES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEROME DAMON (FATHER) 32 N. BERNICE AVE. BALTIMORE, MARYLAND 21229 othert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 5 1

Burial 2

Cremation 3

Removal from State permit. Page Depertment of important: If any injury or once. NEW CATHEDRAL CEMETERY 12-16-2005 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Dintilips Funeral Home, P.A.
1721-24 N. Monroe St. Md 21. Signature of Funeral Service Licer Jonathan D Hibner Monroe St. Raltimore, Md. 000 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Multiple **Physician** gunshet wounds /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to inflinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed PUB Due to (or as a consequence of): Box 68760. by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 □ Unknown signed by Part II. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did Iobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an hes autopsy performed? certificate 1 Yes 2□No : After this certifice e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To YYYes 2□ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury s effer deared Director; After 1 □Naturat subject was shot AM 1 ☐ Yes 2 No 12-9-05 0:30 2 Accident 6 Could not be determined 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 3200 blk of phelps 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) completely filled in by Baltimore To the Hospitel of within 24 hours elected To the Funerel D mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai and manner slated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mis OCME December, 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING mil LI 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Been to freels

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 18 per fh 8850 12-15-05 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40090 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARY R. ECKELS 2005 9:48 PM December 11 4a. Facility Name (If not institution, give street and number, 4c. County of Death Baltimore Baltimore sinai Hospital 0+ N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 05/01/1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2**X** F 68 239-52-7126 Yrs. N. CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD N/ABALTIMORE CITY 1 Yes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2515 PARK HEIGHTS TERRACE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DIRECTORS Elementary/Secondary (0-12) College (1-4or 5+) NORTHWEST HOSPITAL ENVIRONMENTAL 12TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNKNOWN Mary Kate Alphonso Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2515 PARK HEIGHTS TER, BALTIMORE, MD 21215 EDGAR ECKELS, JR/HUSBAND 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PK 12/17/05 RANDALLSTOWN, 4 ☐ Donation 5 ☐ Other (Specify) 23a. Hat Chier the Asease, or complications that caused the death hock, or near failure. List only one cause on each line.

Immediate Cause (Final disease of condition resulting in death) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE. BALTIMORE, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Respirator Hours Due to (or as a consequence of), Pulmonari Teavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 3 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. To the Hospital o within 24 hours aft To the Funeral Di

Physician

/Medical

Examiner

Funeral

Director

in item 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, the Madical Exact at must be rediffed at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Itam 27 is marked other than "

permit. Pages 1 and 2:
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Physician

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To the Funeral Director: After thi
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Examiner

Be Completed by Physician/Medical

Certification: To

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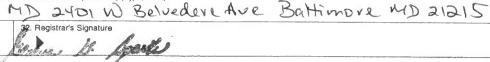
Be Completed by Funeral Director

State Registrar 31. Date filed (Month, Day, Year) DEC 1 3 2005

K. Tonya Mason

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D002PA18

29d. Date signed (Month, Day, Year)

December 11,2003

			1 - For State Registrar	State of Marylar		artment of rtificate o			giene Reg. No.	15 4	0091
*	Physic		Decedent's Name (First, Middle, Last) Cynth	ia Barbara	Evans			2. Date of De Month	Day -	Year 2003	3. Time of Death
	/Medi Examii		4a Facility Name (If not institution, give str	eet and number) whom Mach	cel ca	4b. City, Town	or Location of De	Bwn	4c. Cou	nty of Death	to mole
45.7	Funeral Director		5. Social Security Number 141-34-4719 Usual Residence of Decedent	7. Age (In yrs. 66	Yrs.	If Under 1 Yea Months Day		Sept 5,	y, Year)	9. Birthpla Counti Eng	ace (State or Foreign ry) Land
	within 72 hours after deeth with the Maryland ane. then "natural", or iteme 23a or 28a-f show ite Mudical Exameterment be notified at	Director	10a. State 10b. County Maryland Anne Arun 10e. Street and Number		ty, Town or Lo	denton)		10g. Citizen	of What Countri	d. Inside City Limits 12 Yes 2 No
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21215-0036	vithin 72 ho ne. hen "natu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	DO NOT use reti	ne during most of v red)	3	16b. Kind of	Business/Indu	
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Maryland	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Stree	et and Number or	Rural Route Numbe	er, City or Tou	vn, State, Zip C	Code)
	os 1 and of Health item 27		Charles S. Evans/ H			Hallock sition (Name of	Drive (Odenton,			
nor	00		1 Burial 2 X Cremation 3 Rer 4 Donation 5 Other (Specify)	noval from State	cemetery, cren	natory or other p	1	Date	_	n - City or Tow	
Baltimore,	permit. Pag Department Important: i eny injury o once.		21. Signature of Funeral Service Licensee		D 22	Name and Add	ress of Facility n Funera	2/9/2005 1 Home & oad Oden	Cremat	on, Mar ory, P. arvland	Α.
			23a. Part Enter the disease, or complica shock, or heart failure. List only one	tions that caused the deat cause on each line.						1	Approximate Interval Between
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Division	or A	Certification:	4 Homicide	28e. Place of Injury - At ho building, etc. (Specify	y) 			28f. Location (S City or Tow	n, State)		
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)	X		1	1 m)		04	8000		2/0	8/20	705
1			30. Name and address of person who comp	TEY	201	HOS7	pital	Dr (slen	Bn	rnia, m)
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 2005	32. Jegistrar's Signa	The same of the sa	set !		/			

			For State Registrar		State of Ma		Department of I			2005 . No.	40092
	Physici /Medi Examir	cal	1. Decedent's Name Mars 4a. Facility Name (III	nall		nston			Date of Death Month ECEMbe	Day Ye	5 208PM
	Funeral Director		5. Social Security No. 215-01-5 Usual Residence of	211	ex 7. Ag	e (In yrs. last bin	thday) If Under 1 Year Months Days		Date of Birth (Month, Day, Yember 2)	Balt 8,1914	Birthplace (State or Foreign Country) Maryland
	ryland how		10a. State	10b. County		10c. City, Town	n or Location				10d. Inside City Limits
	he Ma Ba-f s	Director	MD	Baltimo	re	Pil	kesville				1 ☐ Yes 2 No
	3e or 3	i Dir	712 Sil	_{nber} ver Creel	Road		10f. Zip Code 2120	08		. Citizen of What	country? Ses od America
Maryland 21215-0036	72 hours after death with the Maryland netural', or items 23e or 28e-f show alcal Exacitretr ust be notified at	d by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates:			Hispanic Origin? (Specifican, Mexican, Puerto Ric		14. Race - A	American Indian, Vhite, etc.
15-0	n 72 hours "netural', alical Exp	letec	(Spec	15. Decedent's Edify only highest gra	lucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working		b. Kind of Busine	
212	d within jiene. r then "	Completed by	Elementary/Secon	ndary (0-12)	College (1-4or 5	i+)	Owner	30)	V	ending M Company	
pu	be filed tal Hygi d other event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (F	irst, Middle, Ma		
ryla	should be filed and Mental Hygis marked other umatic event, II	스	Marshall 19a. Informant's Na		dmonston,		Maille Add (Charle	Grace Gre	empler_		
	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene, item 27 Is marked other then "netu other treumetic event, Its Musical		Margaret				Mailing Address (Street				yland 21208
Baltimore,	0 0		20a. Method of Disp	osition Cremation 3	Removal from State	20b. Place of	Disposition (Name of y, crematory or other pla	Date	20	c. Location · City	or Town, Stat 21229
Itim		3		5 Other (Specify	"	Metro	Crematory	12/12/0)5 P.	0.Box 2	966,Balto.,MI al Directors
Ba	permit. Departr Importe any inju		21. Signature of Pul	is a solving	Rollno	7	8728 Libe	erty Road, F	Randalls	s runer stown, M	ar Directors aryland 21133
ľ,			23a. Part1 Enter th	disease, or com	olications that caused one cause on each lin	the death. Do no.	ot enter the mode of dyin				Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (disease or condition resulting in death)	Final 1	a. Com w	a consequence of		red pn-	elmo	nia	Onset and Death day S
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c	a consequence of					hours
.O. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12: 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date of Month	delivery Day Year
S, D	gned gned	by	Part II. Other signifi	cant conditions o	ontributing to death be	ut not resulting in	the underlying cause give	ven in Part I.	_	_	a to the cause of death?
Vital Record	e law has b	Completed							24a. Was an autopsy performed	prior death	
/ital	Physician: Th this certificate ral director, pag	Be	25. Was case referr examiner?		11			26. Place of Death (C		No 1 □ Y	es 2 No
of	Phys this al dii	1: To	1 ☐ Yes 2 ☐ 1 27. Manner of Death		Hospital: 1 Inpatie	y 28b. T		4 Nursing Home	5 Residence		(pecify)
ion	Attending r death. ector: After by the fune	ation	1 ☑Natural 2 ☐ Accident	5 Pending investigation	(Month, Day	Year) Ir	ime of 28c. Injur ijury Wor M 1	rk? Yes 2□No		,,	
Division	i Qift o	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, far c. (Specify)	m, street, factory, office	28f.	Location (Stree City or Town, S		Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical		Z Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination and	death occurred at the tire	me, date and place, and opinion, death occurred a	due to the caus it the time, date	e(s) and manner and place, and c	as stated. due to the cause(s)
1	To With	W	29b. Signature and	rufine	Kaji	ln	29c. Licens		(Date signed (Mo	11 2005
£	3		Name and addre	54012	completed cause of de	rtRi	Type, Print) Dad Ran	dallsto	Mn.	dary)	and
DU	Sta Registr	ar	31. Date filed (Monti	DEC 1 3	N 6	r's Signature	Cont.				
SH	MH 17 Rev 1/2	JUI				ORIG	GINAL				

			1 - For State Registrar				nent of h	Health and	-	giene 005	40093
	x 2. 25	30. 5	Decedent's Name (First, Middle, I	ast)					2. Date of De	aath	3. Time of Death
	Physici /Medic		Russell L. Franc	æ					Decen	168 10 21	
	Examir		4a. Facility Name (If not institution, g	11	er)	4b.	÷Λ	or Location of Deat		4c County of De	
		a ;		sex 7	Of Pital Age (In yrs. last b	nighday) If I	Inder 1 Year	edqle If Under 24 Hrs	0 Data of Bi	Balti	more
0.5	Funeral Director		213 36 9468		66	Yrs. Mon			8. Date of Bir (Month, Da March 2	9. E 8 1939 Ma	Birthplace (State or Foreign Country) ryland
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County		10. Cit. T				, MICH Z	O, 1939 Fla	
	the Marylan 288-f show	ō	10a. State 10b. County Maryland Baltimo	re	Tuc. City, 10	wn or Location Essex					10d. Inside City Limits 1 ☐ Yes 2∑ No
	the M	rect	10e. Street and Number				f. Zip Code			10g. Citizen of What	
	within 72 hours after death with the Maryland ene. then "natural; or itame 23a or 28a-f show the Mudical Examinat must be notified at	Funeral Director	312 Lorraine Ave	nue			-	221		USA	oodinity?
	iteme iteme	Jaur	11. Marital Status	12. Was Deceder Armed Forces	s?	13. Was D	ecedent of h	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No	14. Race - Ar Black, Wi	nerican Indian,
0036	rs afte	y Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Mayes 2 ☐	□ [№] _{s:} 1956/59		es 2⊠ No		, , ,		White
0	2 hou sture	Completed by	15. Decedent's	Education		a. Decedent's	Usual Occup	pation		16b. Kind of Busines	ss/Industry
25	ithin 7 19.	nple	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4o	or 5+)			during most of world)			
× 2	filed with Hygiene. other ther	Con	12 17. Father's Name (First, Middle, Las	-1)		Police	Offi			Baltimore	City
and	e d a b	To Be	Eldridge France	it)					ne (First, Middle, Vertra	, Maiden Sumame)	
₹ Z	2 should and Mer is marks aumatic	ř	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Add	Iress (Street	1		er, City or Town, State	Zin Code)
\ \Z	12 mg		Diane F. France (Wife)						, Maryland	
CE			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Stat	20b. Place cemet	of Disposition ery, crematory	(Name of or other pla	ca)	Date	20c. Location - City of	
'α ν C Baltimor	permit. Page Department of Important: if eny injury or		4 □Donation 5 □ Other (Spec	cify)	Garde					Baltimore,	Maryland
Ba S	permit. Departr Importe eny inju		21. Sign ture of Funeral Service Lic	nsee /		Bruzo	and Addre	ess of Facility i Funera	l Home_P	.A.	7.00
) _ [No. of h		23a. Part1. Enter the disease, or co	mplications that caus	ed the death. Do	140 /	mode of dyir	astern Av	or respiratory ar	sex, Ma. 2	Approximate
	Physician		splock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each	ADDIA/	1 Apr	FST	-			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence	e of):					
	LAdminer	2	Sequentially list conditions	b Due to for s	HYPC	TENS	101				
	uted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	EN ED E	Q.	EOTIO	SHOO	10		
ó	ite be executed iysician and ne burial-transit		resulting in death) Last	Due to (or a	is a consequence		XIIC	ONG	N.		
Box 68760,	ate be thysici the bu	licai		d	THE	UMOI	VIA				
9 ×	Physician: The law requires that the death certifica this certificate has been signed by the attending phrail director, page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcom	so of programmy				5		
Bo	death certif	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth	2 Fetal death	h 3 Ectop	ic pregnancy	/		23d. Date of de Month	elivery Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown			(0,000)				
	es tha igned be det	Ď	Part II. Other significant conditions	contributing to death	but not resulting	in the underlyi	ng cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ord	w requir been si should I	Completed							1 🗆 Y	/es 2 ØNo 3 ☐ F	Probably 4 Unknown
Jec Jec	has b	mple							24a. Was autop	sv prior to	autopsy findings available completion of cause of
Ta T	in: Th ificate or, pag		25. Was case referred to medical	T						2 Ø No 1 □ Ye	s 2 No
\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{	ysicia	To Be	examiner?	Hospital: 1 Inpat	tient 2 ER/O	utnationt 3	DOA Oth	er: 4 Nursing H			
Division of Vital Records,	ding Physician: The lav h. After this certificate has funeral director, page 2	T:uc	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inj	jury 28b.	Time of Injury	28c. Injun Worl			dence 6 Other (Spaniow injury occurred	ecity)
sio	Attending ir death. ector: After by the fune	catic	2 Accident Investigate 3 Suicide 6 Could not	on		М	10	Yes 2 □ No			
Jivi	or At after d Direct in by	Certification:	4 Homicide determine	d 28e. Place of Ir	njury - At home, f etc. <i>(Specify)</i>	arm, street, fac	ctory, office		28t Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the bes	at of my knowledg	e, death occur	red at the tim	ne date and place	and due to the o	cause(s) and manner a	ur stated
	the Ho nin 24 t the Fu npletely	Medical	(Check only 2 Medical Exa	aminer: On the basis and manner s	oi examination ai	nd/or investiga	tion, in my o	pinion, death occur	red at the time, o	date and place, and du	e to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier			1	29c. License	e number	Ä	29d. Date signed (Mon	th, Day, Year)
	n. i		Alagae	Sany	Λ	ハレ	Ri	ES 00	0.	Dec. 101	h 2005
(Oth	1	36. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)	ANIK I	IN SO	LADE	HOSO.	OCO CTO TO
*	Sta		31. Date filed (Month, Day, Year)	O32. Pregis	trar's Signature	hoost	-TVICE	110 00	WIRE	must, f	POS CIKIN
	Registra	ar	DEC 1 9	2005 1	in the	11000	Mary .				

Darryl Faulkner 05-08351 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland /	Certificate of			2°005	40094
	Physici		1. Decedent's Name (First, Middle, Las	ext FAULKA	er IR.	1	2. Date of Death Month ECEMber	To 2005	3. Time of Death
į	/Medio Examin		4a. Facility Name (If not institution, give			or Location of Death		4c. County of Death	
			318 N. Grantley S			1timore If Under 24 Hrs.	B. Date of Birth	UA Right	place (State or Foreign
п	Funeral Director		215-04-4368 1	M 2□F 22	Yrs. Months Days	Hours Min.	(Month, Day, Y	ear) a Cou	egland
	land ow		Usual Residence of Decedent 10a, State / 10b. County	10c. City, Tov	yn or Location				10d. Inside City Limits
	Ba-1 eh	Director	HARGIAND N/A	DA HI	MORE				1 Yes 2 No
	with th	Dire	10e. Street and Number	sheet	10f. Zip Code	29	10g	. Citizen of What Cou	intry?
	ome 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		Hispanic Origin? (Spec oan, Mexican, Puerto R	ify Yes or No-	14. Race - Amer Black, White	
36	be filed within 72 hours after deeth with the Maryland hat Hygliene. ed other than "natural", or Iteme 23a or 28e-f ehow event, Ita Medical Exambar must be modified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 □ Yes 2 No		,,	Socity:	American
5-0036	72 hou		15. Decedent's Ed (Specify only highest grad	ucation 16a	Decedent's Usual Occu (Give kind of work done	during most of working	16	b. Kind of Business/li	
121	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Security	ed)	1	5, A. F. E	6
nd 2	2 should be filed and Mental Hygi te marked other aumatic event, ii	BeC	17. Father's Name (First, Middle, Last)		7	18. Mother's Name	-	iden Sumame)	
Maryland	should be nd Mental marked (umatic ev	ပ္	DARRY EURH 19a. loforman's Name/Relationship (7	FAUIKNER Se.	b. Mailing Address (Stree	ICE NA E		/	in Code)
	ges 1 end 2 should t of Health and Mer If Item 27 te marke or other traumatic		//	- mother 3	18 N. Gran	/ /	6	ice MARY/	/
altimore,	Peges 1 enemon of He ont: If Item ory or other		20a. Method of Disposition 1.☑ Burial 2 ☐ Cremation 3 ☐	Removal from State cemete	of Disposition (Name of ery, crematory or other pla	Da Da	te 20	c. Location - City or T	own, State
Hill	교원들 .		4 ☐Donation 5 ☐ Other (Specify 21. Sign rure of Funeral Service Light		MEMOLING PA	RK.	' u	Sord /Acur 1	
ä	Depermine Depermine Important Import		Maure m. E	enelace	DANCY M. 3405 W. FR	ess of Facility COPPCIACE F	BAHIMORE	MARY LAND	21229
ı			23a. Part Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused the death. Do	not enter the mode of dy	ing, such as cardiac or	respiratory arrest	t,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence	on: The				
ı	Examiner		Sequentially list conditions, if any, leading to immediate	b					
7	uted d ansit	Examiner	Cause (Disease or injury	Due to (or as a consequence	of):				
, , ,	icate be executed physicien and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	of):				
8760	ficate be executed physicien and ss the burial-transit	edicai		d					
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3 Ectopic pregnanc	•		23d. Date of deliv	very
P.O. E	The law requires that the death cert sie hes been signed by the ettending page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify)			Month	Day Year
ď.	res that the de signed by the e be detached f	by Ph	Part II. Other significant conditions co	ontributing to death but not resulting	in the underlying cause gr	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ords	w require been sig should b						1 🗆 Yes	2No 3□Pro	bably 4 Unknown
Rec	he law hesb ge 2 sl	Completed		<u></u>			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
ta	lan: T	Be Co	25. Was case referred to medical examiner?			26. Place of Death	1 Yes 2	No 10 Yes	2 No
ot <	Physic this ce al dire	မ	XXX Yes 2 ☐ No 27. Manner of Death		dipatient 3 DOA	her: 4 Nursing Hom			^{fy)} Scene
on	Attending Physician: ir death. ector: After this certifice by the funeral director, i	Certification:	1 Natural 5 Pending 2 Agoident investigation	28a. Date of Injury (Manth, Day Year)	Injury Wo	rk? Yes 2000 S	d. Describe how	Lank es 0	self
Division of Vital Records,	or Attendate death Director:	rtffc	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	arm, street, factory, office	28	of Location (Street, City, or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page		29a. Certifier 1☐ Certifying Ph	ysician: To the best of my knowledge	ge, death occurred at the t	ime, date and place, ar	d due to the caus	se(s) and manner as:	Y, 4247
	the Ho the Fu npletely	dedical	one) 22 Medical Exam	iner: On the basis of examination a and manner stated.	nd/or investigation, in my	opinion, death occurred	d at the time, date	e and place, and due	to the cause(s)
	5 A S P S	Σ	29b. Signature and title of certifier	.14.1	29c. Licen	se number ME		Date signed (Month) $ecember, \ 1$	
	3		30. Name and address of person who	completed cause of death (Item 23a)					
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	111 P	enn Street	Baltim	ore, Maryl	and 21201
	Sta Registr		DEC.1 3 2005	General M. Age	well				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 15

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					Cer	tificate o	of Death		Reg. No.	J 19 0 0	
	Dharaita		1. Decedent's Name (First, Middle, L	ast				2. Date of De	eath Day	Vaca	ne of Death
	Physic /Medi		JOhn	TAGAN				Dec	- 5 =	2005 C	655
7	Exami		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of Deat	h 4c. Count	y of Deeth	
1			BALTO. WASH	. Med C+	Fi		6len	BUNNI	e	AA	
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Ye Months Day	ar If Under 24 Hr		th IV. Year)	9. Birthplace (St Country)	ate or Foreign
	Director		263-40-0903	7	6 Yrs.			July 7		New You	:k
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d Insid	de City Limits
	Aaryli Sho	5	MD Anne An		•	oution,					Yes 2 □ No
	ith the Marylar or 28a-f show	ec e	10e. Street and Number	ander	evern	10f. Zip Code			10= Citi of		
	with a second	Funeral Director		Dwire		Tot. Zip Code			10g. Citizen of	•	
	eath w	era	7922-A Citadel	12. Was Decedent Ever in	IIS 12 V	Mas Doodont o	21144 of Hispanic Origin? (Specify Ven or No		JSA ce - American India	
	aftar des or items miner m	돌	1 ☐ Never Married 2XXMarried	Armed Forces?		Yes, specify C	uban, Mexican, Pue	rto Rican, etc.)		ck, White, etc.	11,
8	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 XXes 2 □ No If Yes, Give Year or Dates:	1	I□Yes 2∏ N	lo Specify:		Specif	y: White	
altimore, Maryland 21215-0020	s 1 and 2 should be filed within 72 hours aftar death with the Maryland f Haalth and Mental Hygiene. I Haalth and Mental Hygiene then "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at		15. Decedent's I	Education	16a. Deced	lent's Usual Occ	cupation		16b. Kind of B	usiness/Industry	
218	hin 7	Completed	(Specify only highest g	rade completed) College (1-4or 5+)	(Give I	kind of work dor OO NOT use reti	ne during most of w	orking		,	
21	d wit	E O	12th	Ø (1-401-54)	Pol	ice Off	icer		US Ar	my	
B	al Hygie other	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Na	ame (First, Middle	Maiden Surnar	ne)	
<u> a</u>	should be nd Mental marked c	70	John J. Fagan,	Sr.			Sara	M. Mani	.on		
an	2 sho and h is ma	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Stre	et end Number or F	Rural Route Numb	er, City or Town	, State, Zip Code)	
Σ	1 and 2 Haalth em 27 i		Toshiko Fagan/W	ife	7922	-A Cita	del Drive	, Severn	, MD 21	144	
<u>S</u>	of He		20a. Method of Disposition		Place of Dispos	sition (Neme of natory or other p	olace)	Date	20c. Location	- City or Town, Stat	е
Ĕ	parmit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other then amy injury or other treumatic event, the Monce.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ify) Ar	lington		,	12/21/05	Arling	ton, VA	
alt	parmit. F Dapartmi importan any injur		21. Signature of Funeral Service Lice	ensee	22.	. Name and Add	dress of Facility				.A.
8	20 E 2 2		Damand	Der M0110	3 3	13 Talb	ott Avenu	ie, Laure	1, MD	20707	
			23a. Part1. Firer the disease, or conshock heart failure. List only			er the mode of d	lying, such as cardia	ac or respiratory a	rrest,	Approx	mate
1	Physician		Ų	. 1			<i>s</i>			Onset a	Between and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	affrence	Scle	enotic	- HEA	rt D	ISCAS	se.	
		<u></u>	,		(or as a consequ		,				
1	nsit	Examiner	_	b							
,	certificate ba axecuted iding physician and isa as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate	Due to (o, as a consequ	иенсе ођ.					
68760,	e ba sicia e bur		cause. Enter Underlying Cause (Disease or injury that initiated events	C							
68	ificat g phy as th	Medical	resulting in death) Last	Due to (or as a consequ	ience oi).				ļ ļ	
ŏ	C 3			d							
m .	Tha law requires that the death ate has been signed by the atter paga 2 should be datached for u	Physicial	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause (niven in Part I	23h Did s	obacco usa co	ntributa to the cau	es of death?
Ö	res that the de signed by the a I be datached f	اچّا	3	To add to a doctor but that to	outing in the dir	donying dadde (given in t are i.		Yas 2□ No		4 □ Unknown
S, D	s tha gned	by P							.as 20110	o Di Tobbably	, Cinalowii
of Vital Records,	v require been sig should b							24a. Was	an autopsy	24b. Were autop	
ပ္ထ	aw requ as been 2 shoul	Bet						репо	med?	available pr completion of death?	
æ	Tha la ate ha paga 2	Completed						1 🗆 \	es 2 No		ZÃ No
ta		BeC	25. Was case referred to medical				26 Place of De	eath (Check only o	/	1 🗆 163	54110
\leq	Physician: this certificarial diractor,	0	examiner? 1Д Yes 2□ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3□ DOA	ther.	Home 5□ Resid		or (Specify)	
	문 는 F	ᇣ	27. Manner of Deeth	28a. Date of Injury	28b. Time of	28c. Inj			now injury occur		
<u>o</u>	Attending I ir daath. ector: Aftar by the funer	ate	1 ØNaturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		onk? ☐Yes 2☐No				
Division	or Attence after deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		et, factory, office	ө			er or Rurei Route f	√u <i>mb</i> er,
Ö	taior A saftar si Direc ed in by	Cer		building, etc. (Opeci	'Y/			City or Tou	ni, Siale)		
	To the Hospital or Attent within 24 hours aftar daati To the Funeral Director: completely filled in by the		Check only 2 Madical Exa	hysician: To the best of my knominer: On the basis of examination	owledge, death	occurred at the	time, date end place	e, and due to the o	ceuse(s) and ma	anner as stated.	se(s)
	To the h within 2, To the F complet	Medical	GIIO)	and manner stated.							
	5 1 × 5 0	-	29b. Signature and title of certifier	12 12	Eputy	29c. Licer	nse number	54	29d. Date signer	d (Month, Day, Yea	r)
			Wellen	The !	mo	100		/	10/3	5/5	
-	1011		30. Name and address of person who		- /	Print)	Ameri	· 0.	0 ox	025	
	V		31. Date filed (Month, Day, Year)	Joves, m.	- 16	10	men	CH CA	5.91	033	
	Sta Registr		DEC 1 3 2005		and the second						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 3 2005

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Loren

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Donald M Wesley Furr 12 2005 16:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1001 N. Woodington Road Baltimore N/AIf Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 6. Sex 1 2 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 7-9-1928 Birthplace (State or Foreign Country) **Funeral** 218-20-9188 77 Yrs Director Md Usual Residence of Decedent r 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "netural", or iteme 23s or the Medical Examiner must be 1001 N. Woodington Road 21229 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bfack, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🎖 ☐ No Black Specify: If Yes, Give Year or Dates: Specify: δ ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than eny injury or other treumatic event, the Me Elementary/Secondary (0-12) 12th grade College (1-4or 5+) 4 Years Post Office Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel B. Furr Hester DaSiell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Furr - Son 2808 Miles Avenue Balto, Md 21211 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 12-14-2005 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md 22. Name and Address of Facility March F/H West 21. Signature of Juneral Service Licenses 4300 Wabash Avenue Balto, Md 21215 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Seguence Examiner certificate be executed physiclen end s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical the ettending IF FEMALE: use 23c. ff yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 1 Live birth 2 Fetaf death 3 Ectopic pregnancy ঠ in the past 12 months? 1 ☐ Yes 2 ☐ NO Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the e P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, cete has been signated to page 2 should to Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 100 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) å. 29b. Signature and title of certifier 29¢: License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 ·Boaten 32 Registrar's Signature 31. Date fifed (Month, Day, Year) State 3 2005 Registrar

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Physician Modification Examiner Facility Name (in not restructor, give stress and number) Formeral Form	Department of Health and Mental Hygiene 05 Certificate of Death	101	2000 40000
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year DECEMBER 11.00PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KANDALLSTOWN
If Under 1 Year If Under 24 Hrs. NES 103 SALTIMORE TH 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) If Under 1 Year Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Min. 12XM 2□ F Hours Director 219-32-4705 69 04 11 36 VΆ Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits ral', or iteme 23a or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2X No Directo MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Rosland Ct. 21208 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural" d other then "natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Janitorial na University Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental 27 is marked of treumatic ever Henry J. Gilmore Ida C. Tatis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Heelth ar Importent: If Item 27 to eny Injury or other treu QDCS. 31 Rosland Ct., Pikesville, Md William Gilmore-Brother 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 12/16/05 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 11. Enter the disease, or complications that ock, or heart failure. List only one cause or Do not enter the mode of dying, such as cardiac or respiratory arrest, caused the death mediate Cause (Final ease or condition ulting in death) **Physician** ALLURE /Medical to (or as a consequence of) Examiner SPIRATO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death signed by the e 5 Other (specify) Records. P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should I 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 No of Vital 1 Yes 2 No To the Hospital or Attending Physicien: : After this certifications a funeral director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Yes 2 No 1 Dippatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending 1 Natural Injury death. 1 Yes 2 No 2 Accident investigation within 24 hours efter deatl To the Funerel Director: completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 💽 cartifying Physician: To the heat of my knowledge, death occurred at the time, date and place, and due to the decests) and mainter as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and Atle of certifier 29d. Date signed (Month, Day, Year) D0063322 DECEMBER, 8, 2003 30. Name and add person who completed cause of death (Item 23a) (Type, Print) MANDEER 5401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		4	For State Ragistrar	tate of Maryland /	Department of H Certificate of	lealth and M Death	Shu	ne 05 L	0102
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Joseph E	. Geyer			2. Date of Death Month December	72, 20°05	3. Time of Death B:10 a M
	/Medic Examin	-	la. Facility Name (If not institution, give stre Gilchrist Center	et and number)	Towso			4c. County of Death Baltimo:	re
	Funeral Director		5. Social Security Number 6. Sex 228-03-1848 1 X M	7. Age (In yrs. last t	oirthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day ebruary 2	(3ar) 1919 Vir	place (State or Foreign ntry) ginia
Maryiand	-f show		10a. State 10b. County MD Baltimor		wn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
h with the	23a or 28a albencti	Funeral Director	10e. Street and Number 8800 Walther Blvd.	, Apt. 4621	10f. Zip Code 21 23	54	10g	. Citizen of What Cou	
5-0036 72 hours after death with the Maryland	al', or Items ? Examiner mu	þ	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 Now II I Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cub		city Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	etc.
121 within	if Health and Mental Hygiene. item 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the Modical Execution man the multilised at	Completed	15. Decedent's Educal (Specify onfy highest grade of Elementary/Secondary (0-12)		ia. Decedent's Usual Occup (Give kind of work done life. DO NDT use retire Attorney	pation during most of workin d)	ng 16	b. Kind of Business/Ir	ndustry
aryland 2 should be filed	Mental Hygi arked other atic event, I	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Charles James	· · · · · · · · · · · · · · · · · · ·		18. Mother's Name	es My	/tinger	Bennett
	Health and I		19a. Informant's Name/Relationship (Type Rosemary Geyer-wife 20a. Method of Disposition	: E	9b. Mailing Address (Street 3800 Walther of Disposition (Name of	Blvd., Ap	t. 4621,		, MD 21234
dies (/)	rtment or rtant: If		1 ☐ Burial 2 XCremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	oval from State Hillto	tery, crematory or other pla op Service Co	^{сө)} эгр 12/1	3/05	Towson, MI Funeral Ho	
Balt permit.	Depa Impo any ii		23a Part 1 Enter the disease or complica	tions that caused the death. D	1050 Yor	k rd., To	wson, MD	21 204	Approximate
/(Ex	ysician Medical Medical the priral-transit	cai Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence)	se of):	l can	ncer		Interval Between Onset and Death Marries
Records, P.O. Box 68760, The law requires that the death certificate be executed	by the attending ph) tached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		у		23d. Date of deliv	ery Day Year
rds, P.	n signed by	by	Part II. Other significant conditions contr	buting to death but not resulting	g in the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	
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on of	After fune	ation: To Be	27. Manger of Death 1 X Natural 5 Pending 2 Accident investigation		o. Time of 28c. Injury Wo	rry at ork?] Yes 2 □ No	me 5 Residen 28d Describe how	rinjury occurred	, , ,
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Div To the Hospital or	within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examine one)	ian: To the best of my knowled r: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
)		-	29b. Signature and little of certifier	my lile		se number		1. Date signed (Month)	21205
espeta.	12+1		30. Name and address of person who com 1. Date filed (Month, Day, Year)	32. Registrar's Signature	20 Rocales	horles St	. Bala	somd e	7021
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ö	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show Joileal Extrainer must be multified at	ed	15. Decedent'	's Education		16a. Dece	dent's Usual Occup	ation			16b. Kind of Bu			
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Maryland	should and Men Is marke	Ė	19a. Informant's Name/Relationsh	iip (Type, Print)			ng Address (Street							
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Baltimore,	of Hea		20a. Method of Disposition	2 □Domoval from Str	1 00	ace of Disponentery, crea	osition (Name of matory or other place	ce)	Da	ite	20c. Location -	City or Town	, State	
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	,		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the death	. Do not en	er the mode of dyir	ng, such as	cardiac or	respiratory arr	est,	Ar	oproximate terval Betw	veen
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t		29a. Certifier 1X Certifying	g Physician: To the be	est of my know	wtedge, deat	h occurred at the tir	me, date an	d place, ar	nd due to the c	ause(s) and mai	nner as state	id.	
	24 h 24 h e Fur	edical	(Check only 2 Medical tone)	Examiner: On the basi and manner	s of examinat stated.	ion and/or in	vestigation, in my o	pinion, dea	th occurred	d at the time, d	ate and place, a	and due to the	e cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens				9d. Date signed			
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	1		30. Name and address of person v	who completed cause	of death (Item	23а) (Туре,	Print)	5/2		· · ·	1	2 6 1 =	217	211.
	2		Kenneth W	Miams	MD	280	1 FOSTCY	Ave	nue	15a1	TIMORE	L, MD	216	24
	Sta	ate	31. Date filed (Month, Day, Year)	32. Deg	istrar's Signa	ture								
	Regist	rar	DEC 1 3	2005	general S	4 A	serle!							

Amend item#18,19a, perFH, G850, 12/22/05 TT State of Maryland 7 Department of Health and Mental Hygione C 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1035 Day Month Year Physician December 10 ESTELLE GOLLUB 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospita Baltimore 09 Baltimore Sinal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Gol 14 1 □ M Director Yrs. OCT 5, 1934 PΑ 201.30.4187 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov traumatic event, the Medical Examiner plust be notified at 1 ☐ Yes 2 ☐ No MD BALTIMORE BALTIMORE he 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā Itema 23a 3855 GREENSPRING AVE. 21211-3301 USA 572 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. W 3₩Widowed 4 Divorced "naturel", $\mathbf{X}\mathbf{X}$ WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 5 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 9 d 2 should be filed within 7 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 3 HOMEMAKER DOMESTIC 18. Mother's Name (First, Middle, Maiden Sumame)

MOLLIE LASTMAN

MARILYN CREENBLATT 17. Father's Name (First, Middle, Last) Be ASHER SILVERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19aMatra 1's Name Gelationship (June Print) f Health MOLLIE LASTMAN 308 KENDIGS MILL RD. OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition

XX Burial 2 ☐ Cremation 3X Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) ROOSEVELT MEM. PK. 12,18.2005 TREVOSE, PA. 19053 21. Signature of Funeral Service L FINK FUNERAL HOME, P.A. GREGORY FINK, DR 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part . Enter the disease, in conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List sho one cause on each line. Approximate Interval Between Immediate Suse (Final disease or condition resulting in death) Onset and Death Physician Due to (or as a consequence of): Cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) pe Physician/Medical nding I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA After thi 27. Mann r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 December 10 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai tospital \geq . Meier 32. Registrar's Signature Goed 31. Date filed (Month, Day, Year) State 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyglene [] 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 3:38p M PATRICIA ANN GRANGER December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIEN BURNIE

If Under 1 Year If Under 24 Hrs.

Months Days Houre Baltimore Washington Medical Center Anne Acundel 8. Date of Birth (Month, Day, Year 3/31/2005 5. Social Security Number Birthplace (State or Foreign
Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2XXF 218-44-6872 60 MARYLAND Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes XXNo Director MD ANNE ARUNDEL LINTHICUM 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a 205 N. HAMMONDS FERRY ROAD 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental GLENN KENNEDY DORIS McCORMICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i MRS. KERRY LYNN DENNIS /DAUGHTER 205 N. HAMMONDS FERRY LANE, LINTHICUM, MD 21090 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State o = 5 1X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of important: if any injury or once. GLEN HAVEN MEM. PK. | 12/13/2005 1 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 MO11 20 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician disease or condition resulting in death) 12 HOURS /Medical Examiner FRACTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine nding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Division of Vital the Hospital or Attending Physician: Be 26. Place of Death (Check only one) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: □Natural 5 Pending 2 Accident
3 Suicide 7/05 1:30 AM 1 ☐ Yes 2 ▼No ACCIDENTAL FALL AT HOME investigation hours after death. Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 205 MORTH HAMMEDS ("En filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a 29a. Certifier cal completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , NO 0060796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n 301 HOSPETAL GLEN BURNIE MO DAINE WILLIAM 32. Registrar's Signature

Registrar

HEALTH ...

		1 - For State Registrar	State of Maryland			of Health a of Death	ind Mental Hy	giene	05	010	6
Physic	ian	1. Decedent's Name (First, Middle, Last) Katherine P. G	ilmer				2. Date of De. Decembe		2005	3. Time of 0830	Death
/Medi		4a. Facility Name (If not institution, give st			4b. City. To	wn, or Location o	f Death	40.0	County of Death	1	
Examir		Baltimore Washing		1 Cent		Glen Bu			ne Aru		
Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1	Year If Under 2					or Foreign
Director		212-24-8436	M 2027 82	Yrs.	Months [Days Hours	Min. Jan 3	1 Year)	23 Mar	yland	
p ,		Usual Residence of Decedent	10- 0-	. Town or Loc						40.1 1-1:4: 0:	
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Ne M	Director	Maryland Anne Ar	undel Gle	n Buri	T	<u> </u>		10 011			
with t		10e. Street and Number			10f. Zip Co			Tog. Citiz	en of What Cor USA	intry?	
9eth	Funeral	466 Glen Mar Ro	ad Apt. A2 2. Was Decedent Ever in U.:	S 12 W	(as Dasadas	21061	nin? (Spoothy Voc. or No	1	4. Race - Amer	ican Indian	
iter d	Ë	11. Marital Status 1 Never Married 2 Married	Amed Forces? 1 Yes 2 ANO	3. 13. VV	Yes, specify	Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	1	Black, White	, etc.	
Jr. or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	11	☐ Yes 21⁄2	No Specify:			Specify: B1	Lack	
2 hou		15. Decedent's Educ	ation	16a. Decede	ent's Usual (Occupation	, , ,	16b. Kir	d of Business/I	ndustry	
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Ment to a stice a stic	ဂ္	Isaiah Pack					Sadonia				
is 1 and 2 should be filed within 72 hours after deeth with the Maryland of the all hand Mental Hygiene. It was a few section of the section of the them section of them 23 or 28e-f ehow other traumatic event, the Madical Examination to incitified at	0.0	19a. Informant's Name/Relationship (Typ	e, Print) (daughter)	19b. Mailing	Address (S	itreet and Numbe	r or Rural Route Numbe	er, City or	Town, State, Z.	ip Code)	
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ges 1		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Re	mayal from State	ace of Dispos	atory`or othe	r place)			cation - City or 1		
t. Pa tmen tent:		4 Donation 5 Other (Specify)					7 12/12/0 821 West				
partition of the proof of the following the following size of the Maryla permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygelene. Department of Health and Mental Hygelene. Department of the marked other then "nature!, or iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinating must be retitined at once.		21. Signature of Funeral Service License		1			Sons Mort				1401
		23a, Part1. Enter the disease, or complice	ese MOU 483						1 / x • 2.	Approximate	
		shock, or heart failure. List only one	cause on each line.	. DO HOL SING	i ilio iliodo c	/	sardiae or respiratory as	1631,		Interval Bette Onset and I	ween
Physician /Medical		disease or condition resulting in death)	Coronory	artu	Sy (Meate				5 year	M'
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the a	sic	1 Yes 2 No	4∏Pregnant at time of de 9∏Unknown	eath 5	Other (spec	fy)			Monta	Day	our
that that the	P	Part II. Other significant conditions cont	ributing to death but not resu	rlting in the und	derlying cau	se given in Part I.	23e. Did to	obacco us	se contribute to	the cause of d	leath?
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ne lav	Completed	-VTV (how)-	· · · · · · · · · · · · · · · · · · ·				24a. Was autop		24b. Were aut prior to o death?	opsy findings a ompletion of ca	avallable ause of
Iclen: The lav certificate has rector, page 2	ဝင္ပ	25. Was case referred to medical			-		1 ☐ Yes	2 No	1 ☐ Yes	2 × No	
ding Physician: The law h. After this certificate has funeral director, page 2	o Be	eyaminer?	ospital: 1 🗌 Inpatient 2 😾	ER/Outpatient	2□ BOA	Othor	of Death Check only o		T015 (0		
Phys ar this aral dir	<u> -</u>	27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at Work?	rsing Home 5 Resid			ny)	
Affer and a	ē	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ N	40				
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s after Dir	Certification:	Tomicad	building, etc. (Specify	,			City of 10	m, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	cian: To the best of my knower: On the basis of examinat	wledge, death	occurred at	the time, date and	d place, and due to the	cause(s)	and manner as	stated.	1
the H in 24 the F iplete	ledi	One)	and manner stated.			 					
T To	Σ	29b. Signature and title of terrifier	MA	,	29c. L	icense number	_	29d. Date	signed (Month	, Uay, Year)	
6		July 1	(171)			3895	0	10/	1/09		
10		30 Name and address of person who con	npleted cause of death (Item	23a) (Type, P	rint)	1	Olen B	, -	8 = 1	2101	,
St	ato	31. Dafe filed (Month, Day, Year)	2. Registrar's Signal	C) COM	11466	way In	oun B	urni	1 MI	21001	,
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			1 - For State Registrar	State of Marylan		artment of H			giene Regin 005	40107	
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last) Set WS 4 Facility Name (If not institution, give s			4b. City, Town, or Location of Death PIKESVILLE		2. Date of Death Day Year 4c. County of Dea BALTIM		Death	
	Funeral Director		RUXTON NURSING 5. Social Security Number 6. Sex 212-22-2489 ¹□ Usual Residence of Decedent 1		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Da 02/0		Birthplace (State or Foreign Country) MARYLAND	
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or iteme 23a or 28a-f ehow any highry or other traumatic event, the Medical Examinar must be notified at Once.	ector	10a. State 10b. County 10c. City, Town or Location BALTIMORE CITY						10d. Inside City Limits 1 1 Yes 2 □ No		
		Dir	10e. Street and Number 2817 MOHAWK AV	/ENUE		10f. Zip Code 2120	7		10g. Citizen of What USA	at Country?	
		To Be Completed by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ Mo		pecify Yes or No Rican, etc.)	14. Race - Black,	American Indian, White, etc. BLACK	
			15. Decadent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12TH	cation completed) College (1-4or 5+)	ompleted) (Give kind of work done during		during most of work)	ring most of working CHES		nd of Business/Industry ESAPEAKE LEPHONE COMPANY	
			17. Father's Name (First, Middle, Last) HARRY WILLIAMS				CARO	LINE BI			
			19a. Informant's Name/Relationship (Typ. MARY C. AMMONS 20a. Method of Disposition 1 Burial 2 Gremation 3 Re	/ NIECE	281		K AVENU	E BAL	${f TIMORE}_{20c.\ Location - Cit}$	MD 21207	
Baltimore,			4 Donation 5 Other (Specify) 21. Signature A leral Service License	ME	22	REMATOR	s of Facility HO	WELL F	CATONS' UNERAL I		
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	cai Examiner									
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		Completed							sy prior dear	re autopsy findings available r to completion of cause of th? Yes 2 \sumbder No	
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										er as stated. due to the cause(s)	
)			29b. Signature and title of certifier	m		29c. License			29d. Date signed (M		
	5		30. Name and address of person who col	mbleled cause of death (Item	23a) (Type,	Print) 838	Gren	Trus	re Rol	21208	
	Sta Registi	-	31. Date filed (Month, Day, Year) DEC 1 3 2005	32. Registrar's Signat	ture	ري	*				

			For	State of Marylan		nt of Health and te of Death		CUUS	40108
10 mg			Registrar 1. Decedent's Name (First, Middle, Last)	: 1	Certifica	ie or Death	2. Date of Dea		3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give s	hey Hosy	ore E	Saltmor	n P	4c. County of De	4
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs		er 1 Year If Under 24 Hrs Days Hours Min.	Month, Day	2.1962 N	rthplace (State or Foreign buntry)
	and		Usual Residence of Decedent 10a. State 10b. County i	10c. Ci	ty, Town or Location		7		10d. Inside City Limits
Baltimore, Maryland 21215-0036	Ra-f sho	ector	Maryland N/A	7		re			1 Yes 2 No
	with the	Funeral Director	2424 Mond	brook A	10f. Z	ip Code 21217		10g. Citizen of What C	Country? A
	r death	Iner	11. Maritaf Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Heatin and Mental Hyglene. arment of Heatin and Mental Hyglene. To refant: If term 27 is marked other than "natural", or items 23s or 28s-f show injury or other treumatic svent. Its Medical Examinar must be multiplied at injury or other treumatic svent. Its Medical Examinar must be multipled at injury or other treumatic svent.	To Be Completed by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: 2	lack
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ıryla			19a. Informant's Name/Relationship (Ty)	Harris	19b. Mailing Addres	SS (Street and Number or R	Thy N	1. KICho	rdson Zip Code)
, Ma			Ms. Dorothy	Baltimore	2424	Woodbroo	K Ave.	Balto.1	Md. 21217
ore	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Item ony injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	Removal from State	Place of Disposition (N. cemetery, crematory or	ame of other place)	Date 19/2005	20c. Location - City o	r Town, State
altin	permit. Pa Departmer Important eny injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tur of Funeral Service License			natory		Balto.	Ma.
ä	Depar Impo) Joseph	L. Kus	1/ Joseph	W. North Ave	uberal Balto	Home, P. A. Md. 2/2/1	0
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and possible completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or burial-transit.	Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part1/Enter the diseles, or compli- shock or heart failure. List only or fmmediate Cause (Finaf	cations that cabeed the deal re cause on each line.	th. Do not enter the mo	ode of dying, such as cardia	c or respiratory ar	rest,	Approximate Intervat Between Onset and Death
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8760,			resulting in death) Last	Due to (or as a consec	quence of);				
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I Re						· · · · · · · · · · · · · · · · · · ·	autop perfor 1 Tes	sy prior to med? death?	completion of cause of
Vita			25. Was case referred to medical examiner?	Hospitaf:	3500		ath (Check only o		16
Division of Vital Records,			1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 [[28b. Time of Injury	OOA Other: 4 Nursing b 28c. Injury at Work?		lence 6 Other (Sp low injury occurred	ecity)Haspios
isioi			2 Accident investigation 3 Suicide 6 Could not be	, M 1 ☐ Yes 2 ☐ No			006 000100 /6	conting (Street and Alumbar or Dural Day to Musely	
DIV			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Factory)						Rural Houte Number,
	Hospit 24 hour Funer stely fills		29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exemination	sicien: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place in, in my opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner a date and place, and du	us stated. ne to the cause(s)
	To the within 2. To the complet		and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Montif					nth, Day, Year)	
)	Λ		Divilliam B		D 008585			12/11/05	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. W. II. Am BEN BICT MO. 150 W. LANVING ST., Backimore, on 21217 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signs	ature	M. ii			
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		1 - For State Registrar	State of Ma	aryland /		rtment of I	Health and N Death		giene Reg. No.	05 1	+0109
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Funeral Director		5. Social Security Number 6. S 577-76-8435 Usual Residence of Decedent	M 2□F	e (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da April	v. Year)	9. Birthp Coun Mary	place (State or Foreign htry) 1 and
land bw		10a. State 10b. County		10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
4 1	ţ	Maryland Charles		Wa	ldorf	•					1 ☐ Yes 2 No
3a or 28a at be not	Funeral Director	10e. Street and Number 15845 Plumage L	ane	, was		10f. Zip Code 206	01		10g. Citizen U.S.A	of What Cour	itry?
Department of Heelth and Mental Hyglene. Important: if items 23a or 28a-f ehow eny injury or other treumatic event. It a Modical Examinational by notified at 2000.	Ď	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	/as Decedent of I Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify:	
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ygier her t		12th			Jase	Worker				Gover	nment
rked ot tic ever	To Be	17. Father's Name (First, Middle, Last) Irvin	Ellis				18. Mother's Nam Alberta		maiden Sui Price	mame)	
27 le ma r treuma		19a. Informant's Name/Relationship (Tommy Humphries		19			and Number or Ru ge Lane W				
et e	1 3	20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other pla	Dec.	Dai 5,2005	20c. Locat	ion - City or To	own, State
nt: if iry or		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi			ity M	lemorial	Gardens		Waldo	rf. Mar	rvland
y inju		21. Signature of Funeral Service Licen	see /		22.	Name and Addre	ess of Facility Le		1 Hom	e, INc.	•
eny i		LUN WWW	Pul Mic	0153	66	33 01d	Alexandri	e Ferry	Road	Clinton	n, MD20735
		23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused	the death. Do	not ente	r the mode of dy	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Moto	tatic	Pa	morest	ic Car	C = -		ļ	Onset and Death
edical		resulting in death)	a. Due to (or as	a consequence		nic rend	1 Cer	lur			
miner		Conventially list conditions	h								
=	ner	Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	or):					11	
hysiclen end the burial-transit	ami	that initiated events	c								
uria}-	ical Examiner	resulting in death) Last	Due to (or as	a consequence	e of):					1	
the b			d								
9 9	Physician/Med	IF FEMALE:	00- 1/								
or us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal deat		Ectopic pregnanc	y		23d.	 Date of delive Month 	ery Day Year
hed	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death	5 🗆	Other (specify) _					,
be detached for use as the		Part II. Other significant conditions o	ontributing to death b	ut not resulting	in the un	deriving cause on	ven in Part I	23e. Did to	phacco use i	contribute to th	ne cause of death?
signe d be	D D	, <u></u>	,g			aony ing oddao gi	or are are a	1 🗆 Y		/	ably 4 Dunknown
should	Completed							V64-24-24-24	-		
9 2 8	ᇛ							24a. Was autop	an 2 sy med?	4b. Were autor prior to cor death?	psy findings available mpletion of cause of
peg .	ខ្ល								2 No		2 No
ector	Be	25. Was case referred to medical examiner?	Hospital:			0+	26. Place of Deal				
al dir	은	1 Yes 2 No	1 LA Inpatie			3[] 00A	4 Nuising n	ome 5 Resid			1)
uner	<u>o</u>	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju	Year) 280.	Time of Injury	28c. Inju		28d. Describe h	iow injury oc	ccurred	
The C	cat	2 Accident investigation 3 Suicide 6 Could not be	1 4/14	At hama	fa		Yes 2 □ No	OR Leasting /	N A1		/ 0 11
in by	Certification:	4 ☐ Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	rarm, stre	et, tactory, office		City or Tou	m, State)	um <i>ber or H</i> ura	il Route Number,
c-mpletely filled in by the funeral director, pege 2 :	edicai Ce	(Check only 2 Medical Exan	ysician: To the best of the basis of	examination a	ge, death and/or inve	occurred at the ti	me, date and place, ppinion, death occur	and due to the cred at the time, c	cause(s) and	d manner as st	ated. the cause(s)
mple	Med	29b. Signature and title of sertified	and manner sta	ited.		29c. Licens	e number		29d Data si	igned (Month, I	Day Vear)
8		13. Fa	legh	l		250. 25011.	1)005-	7100	12,1	11,200)5
		30. Name and address of person who Behzad K	completed cause of d	eath (Item 23a)) (Type, P	11701	livingsto	n Rd.	#103	Fity	Day, Year) 05 Vashy In, M 20+4+
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			V				20144
7 Rev 1/2		UEC 1 3	2005	340 B	A	and I					
			9	(ORIGI	NAL					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.5For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician IRMA AUDREY HARVEY 11, 2005 DEC. 6:55P [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOSEPH RICHEY HOSPICE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01 / 06 / 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛛 F Yrs. 135-46-6094 68 Director GUYÁNA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits to fleatih and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be not litted at PRINCE GEORGE'S MD HYATTSVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2622 KIRKWOOD PLACE #201 20782 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Anned Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH 4 YEARS REGISTERED NURSE HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LIONEL TELFORD EMILY WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES HARVEY / HUSBAND 4604 OLIVER STREET, RIVERDALE, MD 20736 20a. Method of Disposition

XXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State ö permit. Page Department of Important: If any Injury or MD NATL MEM. PK 12/18/05 LAUREL, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES R. 21. Sign wire of Funer HINDS FUNERAL SV 12303 KAYAK DR., UPPER MARLBORO, MD 20772 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Glioblastoma Physician disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death entificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical use as the ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 Yes : After this certification of funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide

68760. Box P.0. Records. Division of Vital Hospital or Attending Physician: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plates and due to the reviso(s) and increase stated

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Patrimore, MD 21201

29b. Signature and title of certifier

150 MD

29c. License number 1724170

December 12, 2005

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

Medical

His ice 32. Registrar's Signature

30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print)

DEC 1 3 2005

		1	For State Registrar	State of Maryland /		tment of He <i>ficate of E</i>		ental Hygier	.000	40111
	• ,		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medić		MARY GLADYS HEPW	ORTH			D:		9, 2005	7:55 A. ^M .
	Examin		4a. Facility Name (If not institution, give s		4		Location of Death		4c. County of Dea	th
			FOREST HILL HEALTH			FORE:	ST HILL If Under 24 Hrs.	O Color of Sign	HARF	
	Funeral Director		217-12-9400	M 2 💢 F 7. Age (In yrs. last)		Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Jan 28 1	924 9. Bir	thplace (State or Foreign ountry)
	land	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	tion		***		10d. Inside City Limits
	Many -1 sh	ţō	Maryland Anne A	rundel		Pas	adena			1 ☐ Yes 2 💢 No
	h the	lrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23e c	ralD	721 Powhatan Beach	Road		2′	1122		USA	
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or Items 23e or 28e-f show very injury or other treumetic event, it a Madical Examinar must be naillified at ODGe.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		as Decedent of His es, specify Cubar Yes 2 X No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whi	
2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation 16 completed)	(Give kir	nt's Usual Occupa nd of work done d	uring most of working	g 16b	. Kind of Business	/Industry
2121	within ene. then	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		o <i>Notu</i> se retired) oley Line		51	Manufact	urina
р 5	filed Hygi other ent, I		17. Father's Name (First, Middle, Last)		713301112		18. Mother's Name			urring
<u>la</u> n	fental rked ric ev	To Be	Jasper T. V	/illiford			Lucinda	Tayl	or	
Maryland	and N is ma		19a. Informant's Name/Relationship (Type	pe, Print) 1	19b. Mailing	Address (Street a	nd Number or Rural	Route Number, Ci	ty or Town, State,	Zip Code)
<u>ک</u>	and lealth m 27 her tr	1		daughter)	721 F	Powhatan	Beach Rd.			
altimore,	t. Pages 1 rtment of P rtent: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature Funeral Syrvice Lights	emoval from State	Haver	ion (Name of tory or other place Cemete)	Dec. 200	13)5 G1		e, Maryland
Ba	permi Depa Impo eny ir		Volud. By	4 11	3		ntain Road	d, Pasade		Home, P.A.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations hat caused the death. Declared us on each line.			A	respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Send ston	1	leunt	in			
	Examiner			Due to (or as a consequent	of);					
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	acuted nd transi	aml	cause. Enter Underlying Cause (Disease or injury that initiated events							
60,	icate be executed physicien and s the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a consequent	ce of):					
68760,	physics the k	dle	d							
P.O. Box (death certif e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	ath 3□E	ctopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	that the post of t	y Ph	Part II. Other significant conditions con	tributing to death but not resulting	ng in the und	erlying cause give	n in Part I.	23e. Did tobaco	co use contribute t	o the cause of death?
rds	quires in sign	ed by	alcarl Lebe	Ilehan				1 ☐ Yes	2 □ No 3 □ P	robably 4. Unknown
Vital Records,	Physicien: The law requires that the rthis certificate has been signed by the raid director, page 2 should be detach	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ital	Physicien: rthis certifica ral director, p	BeC	25. Was case referred to medical examiner?				26. Place of Death			
of V	hysic this co	은	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER/		3□ DOA Othe	4 Nursing Hom	e 5 🗆 Residence		ecify)
	ling F	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28t	b. Time of Injury	28c. Injury Work		8d. Describe how in	njury occurred	
Division	Attending in death.	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	a. farm. stree		′es 2□No	8f. Location (Street	and Number or R	ural Route Number.
<u>S</u>	el or A s after sl Direct	Certification:	4 Homicide determined	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, Si		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medicel Exemin	icien: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death o and/or inves	occurred at the tim stigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	To the l	W/	29b. Signature and title of certifier	D .		29c. License	3 2 2 7		Date signed (Mont	12, 2005
•	1/		30. Name and address of person who co DR. DAVID DUNN -			int)				, ,
	Sta	ate	31. Date filed (Month, Day, Year)	615 W. MACPHAI 32. Registrar's Signature	9.4		L AIR, MD	. 21014		
	Regist		DEC 1 3 2005	Simul & A	and l	7				

			For State Registrar	ate of Mary	land / Depa <i>Cei</i>	artmen rtificate	t of H e of L	ealth and N Death		ene ()	5 L	0112
п	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Death	n Day	Year	3. Time of Death
	/Medic		Norman Allen Hedri						Dec.		2005	12:45 A M
	Examin	er	4a. Facility Name (If not institution, give street	and number)				Location of Death		1	y of Death	
			Manor Care Ruxton 5. Social Security Number 6. Sex	7 Age /lr	yrs. last birthday)	If Under	DWSO	If Under 24 Hrs.	8. Date of Birth	Balt	imore	lano (Stata or Fornisa
	Funeral Director		217-18-6932 XM		**	Months	Days	Hours Min.	Dec. 19	Year) 1920	Cour	lace (State or Foreign htry)
			Usual Residence of Decedent			1			15001 15	132.0	1311	
	anylar show	_	10a. State 10b. County	10	c. City, Town or Lo	cation					1	0d. Inside City Limits
	the Marylar 28a-f show	ecto	MD Baltimore		Sparks							1 ☐ Yes 2 ☐ No
	with the	Ē	10e. Street and Number 4 Rainflower Path #	201		10f. Zip			10	g. Citizen of		ntry?
	eath	eral		Z U I /as Decedent Eve	rin IIS 13 1		1152		acifu Vas or No-	US	ce - Americ	ean Indian
10	fter d r Iten	Funeral Director	A	med Forces? ∑Yes 2 No Yes, Give	10.0.	If Yes, spec	ify Cubar	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		ick, White,	
93	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show Jisal Examiner was the confided at	by	3 ☐ Widowed 4 ☐ Divorced Y	Yes, Give ear or Dates:		1 ☐ Yes 2	2 No	Specify:		Speci	^{fy:} wh	nite
21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade con		16a. Dece	dent's Usua kind of wor	il Occupa rk done d	ation furing most of work	ina	6b. Kind of E	Business/Inc	dustry
121	vithin ne. hen.	mpi	Elementary/Secondary (0-12)	ollege (1-4or 5+)				furing most of work)				
2	filed within Hygiene. other then "		12 17. Father's Name (First, Middle, Last)	3	Radio	Engi	ineer	18. Mother's Nam		roadca		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23s or 28s-f show or other treumettic event, the Modical Examination ust boundliked at	To Be	Norman Robert Hedi	rick				Rachel		alderi obina	1110)	
ary.	shoul nd M	i i	19a. Informant's Name/Relationship (Type, F		19b. Mailir	ng Address	(Street a	and Number or Rur		City or Town	, State, Zip	Code)
	1 and 2 Health a tem 27 is		Mary Jane Hedrick/	wife	7.1			ath #201			2115	-
Jre,	es 1 a of He of He r othe	1	20a. Method of Disposition		20b. Place of Dispo	sition (Nam	ne of			Oc. Location		
<u><u>Ĕ</u></u>	Pages ment of h ent; If ite ury or of		1 XBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai from State	Druid Rie	dge C	Ceme	tery 12/9	9/05	Pikes	ville,	MD
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		21. Small Land Europa Service Com	W	Le Le	2. Name and emmor	Address	s of Facility neral Ho onia Rd.	me of Du	laney	Valle	y, Inc.
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the	death. Do not ent	er the mode	e of dying	g, such as cardiac	or respiratory arre	st,	270	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):							
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,	be executed sician and burial-transit	Examiner	that initiated events c. esulting in death) Last	Due to (or as a co	nsequence of):		_				-	
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9	rtifical ng ph as th	ledi	ICCC III			-						
Вох	death certifica attending ph d for use as ti	an/h		yes, outcome of p		Ectopic pre	egnancy				ate of delive	,
O. E	ne dea the at hed fo	Physician/Medical	1 Tyes 2 TNo	□Pregnant at time □Unknown		Other (spe				M	onth	Day Year
Ρ.	hat th od by detacl	Ph)	Part II. Other significant conditions contribu	ting to death but or	at resulting in the u	nderhing of	auce ave	in in Part I	23e Did tob	2000 1159 000	tribute to th	e cause of death?
Records,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	ted by				idonying oc		THIT GIVE	1 Yes		3 □ Prob	
S	e law r has be je 2 sh	Completed							24a. Was an autopsy		Were autop	osy findings available
E H		Cor							perform 1 Yes 2		death? 1 ☐ Yes	2 No
of Vital	Physicien; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al·			Otho	26. Place of Deatl)		
of	S S S	. To	TES ZIZINO	1 L Inpatient	2 ER/Outpatien	and the same of the same of	1000	4 Thursing Ho	me 5 Resider 28d Describe how			")
on	iding f th. After funer	tion	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	a. Date of Injury (Month, Day Ye	ar) Injury	м	Bc. Injury Work 1 [] Y	? ′es 2 □ No	200. Describe not	V IIIJury Occur	160	
Division	Attending r death. ector: After	ifica	3 Suicide 6 Could not be	e. Place of Injury	At home, farm, str	eet, factory,	, office		28f. Location (Stre	et and Numi	ber or Rura	Route Number,
Ö	s after s after sl Direct	Certification;	4 Homicide determined	building, etc. (S	респу)				City or Tòwn,	State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director; After th completely filled in by the funeral	edicai (29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner:	n: To the best of m On the basis of exa and manner stated.	y knowledge, death amination and/or in	occurred a vestigation,	at the time in my opi	e, date and place, inion, death occurr	and due to the car ed at the time, da	use(s) and m le and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7 /	7		License			d. Date signe		
. ,			Jer /4			O. H	005	54424	1	2-8	-05)
6	41/	2	Name and address of person who comple		(Item 23a) (Type, um rd.		20	9 Times	Num M) 210	93	
Ĭ	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 200					, (tyricr	cocres / /i			
		- 3	DEG + 9 700	M AND SHAPE	See Jest See	-	-					_

DHMH 17 Rev 1/2001

3		1.	For State Registrar	State of Marylant	d / Department o <i>Certificate o</i>			2005 40113	
Phys	sician		Decedent's Name (First, Middle, Las	" — // /			2. Date of Death Month	Day Year 3. Time of Death	h
/Me	edica	-	Facility Name (If not institution, give	street and number)	4b. City. Tow	n, or Location of Deal	Decembe	er 7, 2005 10:15 a	М
Exa	mine		3016 Taylor Aven	100		ville		Baltimore County	
Fune Direct		5.	Social Security Number 6. Se 70-58-1767	7. Age (In yrs. Iz		ear If Under 24 Hrs lys Hours Min.	(Month, Day, Y	(ear) 9. Birthplace (State or Fore	eign 7
D		-	sual Residence of Decedent	100 60			0 25-6	03 Johnstown, PH	
Maryla fehov	١		Da. State 10b. County	MORE 100. City	, Town or Location	10=		10d. Inside City Lim 1 ☐ Yes 2	
th the l	lrec	10	e. Street and Number	MORC	BALTIM 10f. Zip Coo		10g	. Citizen of What Country?	
sath wi	Filmeral Director	5	7624 Danie	Is Ave.		11234		USA	
6 after de or item	Fills	3 11	. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 MNo	If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. important: if item 27 is marked other then "neturel", or items 23a or 28a-f ehow any holdry or other traumatic event. The Medical Examinar must be could also	1 2		3 Widowed 4 Divorced	Year or Dates:	1 ☐ Yes 2 【2	· · · · · ·		Specify: White.	
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laryla 2 should and Men is marke			9a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address (Str	eet and Number or R	ural Route Number, C	City or Town, State, Zip Code)	
t and theelth		20	a. Method of Disposition	ins tat/()	440 (mb)	ia St 1	Date 20	c. Location - City or Town, State	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RUFUS ath HURSE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER BALTIMORE MERCY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, Year)

July 22, 19, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 58X 1**0**2M 2□F 216-32 7348 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 ehow eny injury or other traumatic event. It is Mardical Examiliar traumatic event. 1 Tes 2 No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 1224 AVENUE USA Wood 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. þ Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IRANSDORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5/5/cR 170

20b. Place of Disposition (Name of cometery, crematory or other place) HardIN 20a. Method of Disposition
1 Burial 2 Cremation 20c. Location - City or Town, State 3 Removal from State 4 □ Donation 5 □ Other (Specify) t. Crem tow! 1.
22. Name and Address of Facility
Bradey-A2134 W 21. Signature of Funeral Service Vicense SKTON Heral Home MO1455 110W Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Hypercalcemia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ 100 24a. Was an autopsy performed? 1 ☐ Yes 2 000 To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18556 MD ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add YANIS SCUTH GREENE STREET, BALTIMORE, MARYLAND EMLIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 3 2005 Registrar

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Courtney Housand	

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Depertment of Health and Mental Hygiene.	Importent: If Item 27 ie marked other then "naturel", or Items 23a or 28e-f ehow	eny injury or other traumatic event, the Madical Examiner must be notified at
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	permit. Pages Department of Importent: If it eny Injury or o		21. Signature of Fu	uneral Service Lice	nsee									Home, PA	
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5	r this	<u>۔۔</u>	27. Manner of Dear		1 ☐ Inpatie		R/Outpatien 8b. Time of			4 🗆 Nursing	Home 5 ☐ Re		6 Other (S	pecify) Scene	
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<u>ב</u>	s effe s effe el Dir	Certification:	4 _ Homelde		building, etc		Road				NE New	Konst	Rd 41en	en Jersey Al	11
1	To fine hospitel of Attending Priystoner: The law requires then the death certificate be executed to the Hospital state of the fine for the fine for the following physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier (Check only one)	1☐ Certifying Ph	niner: On the best of	examinatio	edge, death n and/or inv	occurred vestigation	at the time	, date and place nion, death occ	on and due to the		(a) - a d		
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	V)		30. Name and add	ress of person who	completed cause of de	eath (Item 2									
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	Sta Registr		31. Date filed (Mor	DEC 1 3 2	32. A b gistra	r s Signatu		meli	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** SHAWN KING 19:09PN KENYON DECEMBERG, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ST. HENES CITY ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number N/A 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 18 M 2□F 10 DECEMBERGZOS MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Modical Exercises must be netitied at 10d. Inside City Limits MARYLAND 1 Yes 2 No Director HOWAR DLUMBIA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? BROOK WAY# UNITED STATES 21044 5324 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Colfege (1-4or 5+) NEW BORN 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KENNETH SCOTT KING VERONICA ELAINE HILEN 19a. Informant's Name/Relationship (Type, Print) FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trat once. SCOTT KING-5324 BROOK WAY COLUMBIA, MARYLAND KENNETH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State NECITERIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility tureral Randallstown Md 21/3 a. Dert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between EXTREME REMATURITY Onset and Death fmmediate Cause (Finaf **Physician** disease or condition resulting in death) 10 MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. ONE 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D58 793 DECEMBER 6,2005 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Chey ROLET DRIVE MAUREEN MUNEKE, MD ELLICOTT CITY, MARYLAND 21042

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 3 2005

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year DECEMBE 7.00 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 ☐ M 21X F 030 46 5066 Director April 2,1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location wohe 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28a-f ehov traumatic event, tra Mudical Exertinar must be notified at Maryland Director Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Reverdy Rd. 21212 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or item any injury or other traumatic event, the Mudical Exempleations." 1 Never Married 2 ☐ Married □Yes 2⊠No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Yes. Give þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Harold Keitz Mary Mariah Ryan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kellie McLaughlin (Daughter In Law) 8439 Kavanagh Rd. Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 12/13/2005 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. Mikallere 1407 Old Fastern Avenue Essex, Md. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIA ACUTE /Medical Due to (or as a consequence of): Examiner ONAR AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 2 No this certificate 2 No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗋 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Dave filed (Month, Day,

DEC 1

2005

32 Registrar's Signature

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RALTIMORE

			1 - State Registrar	ate of Maryla		rtment of He tificate of D			iene 05	-	0118
	Physici		1. Decedent's Name (First, Middle, Last) Samuel K	ing				2. Date of Dea Month Decembe	D.	Year 005	3. Time of Death 8:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give street Care Center at Oak C		200	4b. City, Town, or I	Location of Death		4c. County o	f Death	
>	Funeral Director	40	5. Social Security Number 6. Sex 1 ★ M 2	7. Age (In yrs	s. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day AUG 20	1		inore place (State or Foreign ontry) MD
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation				1	Od. Inside City Limits
	Sa-f si	Director	Maryland Baltimore)			cville				1 ☐ Yes 2 ☐ No
	th with the 23a or 2		10e. Street and Number 8810 Walter Blvd. Ap	t.1223		10f. Zip Code	21234		10g. Citizen of WI US		itry?
350	d within 72 hours efter deeth with the Maryland Jene. r than "natural, or itama 23a or 28a-f show The Mucical Exarcia arrount be incilling at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in med Forces? Yes 2 No Yes, Give ear or Dates:	If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White,	can Indian, etc. 11te
2-0036	72 hou		15. Decedent's Education (Specify only highest grade com	pleted)	16a. Deced	ent's Usual Occupat kind of work done du OO NOT use retired)	tion uring most of worki	ng	16b. Kind of Bus	iness/în	dustry
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and	be filed tal Hyg d othe	Bec	17. Father's Name (First, Middle, Last)	_			18. Mother's Name)	
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e, Ma	s 1 end 2 should f Heelth and Men item 27 is marke other traumatic		Joan Manning (dau	ghter)	630	Hastings	Road, To	wson, M	21286	,,	
altimore	permit. Pages 1 Department of Hi important: If iter any injury or oth		20a. Method of Disposition 1 □ Burial 2 [XCremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	al from State	amily Cr	ernation S	Berv. Dec.	00		on,	Delaware
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	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	<i>J</i>					
**	uted T ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):						
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rds, P	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contribut	ing to death but not re	esulting in the un	derlying cause giver	n in Part I.			oute to th	ne cause of death?
Vital Records	The ste h page	Completed	parkeyon) stra	sec.	<u>t</u>		24a. Was a autops perfor	med? de	ath?	psy findings available mpletion of cause of 2 No
	Physician: rthis certificant	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2[☐ ER/Outpatient	Other	26. Place of Death				
n of		on: To		a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ence 6 Other		/)
DIVISION	ne se	licati	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At	home farm stre	M 1 🗆 Y	es 2 No	28f Location /S	treet and Number	or Pum	J. Pouto Alumbos
2	ital or firs after ral Dire	Certification:	4 Homicide	building, etc. (Spec	cify)			City or Tow	n, State)		
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by the	Aedical		I: To the best of my kr On the basis of examin and manner stated.	nowledge, death nation and/or inv	estigation, in my opi	nion, death occurr	ed at the time, o	late and place, ar	nd due to	the cause(s)
1	o o o o o	Σ/	29b. Signature and title of celtifular	The	M	29c. License	number	12	9d. Date signed	(Month.	Day, Year)
-	10pl		30 Name and address of person who comple	ted cause of death (It	23a) (Type, F	Print) W.I	They is	100	Parker	48	dud 21234
* ************************************	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 3 200	32. Revistrar's Sign	nature	parli					

Kowalczyk, Anthony

			For State	•	ck Indelible Ink. Ensure A Department of Health and Certificate of Death	Mental Hygie	re 05	40119
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anthony	М.	Kowalczyk	2. Date of Death Month	2005	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give st Baltimore Washingt 5. Social Security Number 219-30-4763 Usual Residence of Decedent		4b. City, Town, or Location of Deat Glen Burnie If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Co	
bachach	or 28a-f ehow	tor	10a. State 10b. County Maryland Anne Arun		wn or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
at yidiind E i E i 3-0000	I feath and feather green from the four states death must the many ten must be many the feath and feather han "natural", or items 23a or 28a-f eho ten 27 is marked other than "natural", or items 23a or 28a-f eho ten 27 is marked other traumatic avent. It a Madical Examinar must be notified at	by Funeral Director	10e. Street and Number 337 Magothy Blvd.	2. Was Decedent Ever in U.S. Armed Forces? 1 ⊮Yes 2 □ No If Yes, Give Year or Dates:	10f. Zip Code 21122 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:		U.S.A. 14. Race - Ame Black, White Specify:	ncan Indian, a, etc.
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yiaira Podaba	and Mental Hygiene. Is marked other than raumatic avent, Ita Me	To Be	17. Father's Name (First, Middle, Last) Steve 19a. Informant's Name/Relationship (Typ)		alczyk Lucy Db. Mailing Address (Street and Number or Ri	me (First, Middle, Maid	Gov	voeky
2, 14	perint. rages i and a signal and bepartment of Health and Important: If them 27 ler eny injury or other traurants.		Jeraldine Kowalczy 20a. Method of Disposition 1	k (Wife) 3 20b. Place cemet	337 Magothy Blvd. Pas of Disposition (Name of ery, crematory or other place)	adena, Mar Date 20c.		22 Town, State
	Departm Departm Imports eny inju		21. Signature of Funeral Service Licenses		22. Name and Address of Facility McCully-Polyniak F 3204 Mountain Road			
	hysician /Medical xaminer		23a. Pand. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do cause on each line. Renal Ce Due to (or as a consequence)	onot enter the mode of dying, such as cardial U Carcinoma e of):	c or respiratory arrest,		Approximate Interval Between Onset and Death
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ומו חפרט	rate has bee	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 Ø 1	death?	lopsy lindings available completion of cause of
5 6	to the most after death within 24 hours after death within 24 hours after death within 24 hours after death after this certificate has completely filled in by the funeral director, page 2	tion: To Be	27. Mann of Death 1. Natural 5. Pending		Othor	ath (Check only one) Home 5 Residence 28d. Describe how in		cify)
DIVISION	no the nospital or Attenuing within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street City or Town, Sta		ral Roule Number,
	in 24 hour the Funerapietely fills	edical	(Check only 2 Medical Exemination one)	 On the basis of examination a and manner stated. 	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	urred at the time, date a	and place, and due	to the cause(s)
,		M	29b. Signature and title of certifier	Wills	M.D. 29c. License number D41365	Dec	Date signed (Monti	9, 2005
1	びソ	1	30. Name and address of person who con George E. Wick.	npleted cause of death (Item 23a	Type grini) NOSpital Drive,	Glen Buri	nie, MD.	21061
1961	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 3 2005	32. Registrar's Signature	DEMONST.			

			For State Registrar	State of Maryland		artment of H			jiene) 05	40120
	۰		Decedent's Name (First, Middle, Last)	1/	1 .			2. Date of Dea Month	th	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		1924	9. Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	ocation				10d. Inside City Limits
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	th the	lrec	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of Wh	at Country?
	23a ust b	ral	420 Shady Lane			_1	21122			USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, the Mcdical Examine must be notified at ance.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
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Mary	d 2 sho th and 1 7 is me trauma	1 18	19a. Informant's Name/Relationship (Type Stanley G. Holewin			-		Rural Route Number adena, MD		ate, Zip Code)
ē,	s 1 an f Heall tam 2 other		20a. Method of Disposition	20b. Pl		osition (Name of matory or other place			20c. Location - Ci	ity or Town, State
E	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	amovan rom State		ematory Ir			Baltimore	e, Maryland
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service License	VAII.) 22	2. Name and Addres				Home, P.A.
			23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	cations that caused the death		ter the mode of dying	g, such as card		rest,	Approximate Interval Between
	Enysician	Ž W	Immediate Cause (Final disease or condition	Chronic	065	truite P)_ lmun	5 Dis	1959	Onset and Death
	/Medical- Examiner		resulting in death)	Due to (or as a consequ	ence of):					
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
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Д.	es gu	by	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	inderlying cause give	en in Part I.	23e. Did to		oute to the cause of death?
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Division	after dealt after dealt Director: d in by the	er ification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, st	reet, factory, office		28f. Location (S City or Town		or Rural Route Number,
	To the Hospital or At within 24 hours after corporately filled in by completely filled in by	edical C		ician: To the best of my knowner: On the basis of examination and manner stated.						
	To the within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License				(Month, Day, Year)
)	, ,	1	1/2	MN		D4.	1447	ĵ.	Decembe	9,2005
(2/2		30 Name and audress 1 person who co	pleted cause of death (Item	23a) (Type,	Print) Chu	u la	in (a	tensuill	9,2005 6 mar
•	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NFC 1 3 2005	2. Registrar's Signat	ure for	des	· · · · · · · · · · · · · · · · · · ·			

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State of Maryland / Department of Health and Mental Hygiene 0 5 Francis L. Krol 05-08256 crn 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Francis December 07, 2005 Lerov Kro1 9:40 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1404 Amphibian Drive Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 № 1M 2 🗆 F Yrs. 50 Oct. 216-68-7760 1955 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural, or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** death 1404 Amphibian Drive 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: White Specify: þ 3 ☐ Widowed 4 BDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Marine Electrician Coast Gue 18. Mother's Name (First, Middle, Maiden Sumame) 12 Coast Gueard Yard 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if Item 27 is marked oth eny lipiry or other treumatic event <u>ones.</u> Be Τ. Frank Margaret Krol V. Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis T. Krol Jr. (Brother) 3911 Longmoor Circle, Phoenix, Maryland 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Dec 12, 2005 Brooklyn Park, Md. 22. Name and Address of Facility 21. Signature of Fundal Service Licensee McCully-Polyniak Funeral Home P.A.

3204 Mountain Road, Pasadena, Mary

shock, or heart failure. List only one cause on each line. Maryland 21122 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic (Heroin) Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a sion of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? Yes 2□ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specifyat Scene 1 Yes 2 □ No Certification; To Print(Month, Day Year) 28b. Time of unk. 27. Manner of Death 28d. Describe how injury occurred Unk. After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 No death. 12/7/05 2 Accident i or Attend efter death Director: / 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) **1404 Amphibian Dr** 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Home To the Hospital of within 24 hours of To the Funeral D Pasadena, MD 29a. Certifier (Check of one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Tymedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 08, 2005 who completed cause of death (Item 23a) (Type, Print) 30. Nan

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month,

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Veal ANA DECEMPER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Year If Under 24 Hrs.
Days Hours Min 16K 2005 Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 9 358-10-1582 Director Yrs. 1/1926 NN Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location rthen "natural", or Items 23s or 28s-f show the Modicel Examiner must be notified at 10d. Inside City Limits Recentific 1 Tes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ST. 17 WEST NITED Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ackey, bou and College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ENGEL P)NKN(19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MACHE CATEWOOD SELL / DAUGHTER TIWEST 29th ST. PALTIMORE MD 31318

20a. Method of Disposition

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burjal 2 Cremation 3 Removal from State ANATOMY GIFTS REG 12/9/05 HANCVER, MD 4 Defonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AUDITOHY GIFTS PEGISTRY 7522 CONSULEY DR HANDWERMS 21076 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gilobiastoma **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit Due to (or as a consequence of): siclen a burial-1 Box 68760, Completed by Physician/Medical physi the b ding pl IF FEMALE: use use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. cartificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 A No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) NOSpi Ce 1 Yes 2 No P 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending Injury after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) MO D0051926 December 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles St Helen M. Gordon Rathman MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

	1	For State Registrar	of Maryland / D		artment of tificate o		d Mental Hy	giene Reg. No		40123
Physician		Decedent's Name (First, Middle, Last)		т _			2. Date of D Month	Da	y Year	3. Time of Death
/Medica	1	Robert a. Facility Name (If not institution, give street and	number	La	Valle	or Location of De	DECEME		2005 County of Dea	11:55 A.
Examine		MALCOLM GROW MEDICAL (CAMP SI		Jan 1		INCE GE	
Funeral Director		6. Security Number 014~12~5450 6. Sex 1 ☑ M 2 □	7. Age (In yrs. last birth	rs.	If Under 1 Yea Months Day		8. Date of B (Month, D	irth	9 Bi	rthplace (State or Forei ountry) VIOII . MA
f show lad at		Jsual Residence of Decedent 10a. State 10b. County Maryland Frince George	10c. City, Town		cation Temple	Eills				10d. Inside City Limit
ritems 23a or 28e-fs		10e. Street and Number 6014 Summerhill Road		-	10f. Zip Code	,		10g. Cit	tizen of What C	,
ems 230	בום	11 Marital Status 12. Was I	Decedent Ever in U.S.	13. \		2074.8 Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0-	U.S 14. Race - Am	erican Indian,
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Department of Health and Mental Hygiene. Importent: If item 27 Ie marked other than "naturel; or Items 23a or 28e-f show enty inury or other treumatic event, the Modical Examinat, unit by ruillibut at once. TO Be Commissed by Funeral Director	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	ed) (1-4or 5+)	Give lite. L		e during most of (red)			ind of Business	,
d otherti event, III	ט פ	17. Father's Name (First, Middle, Last)	I Kei	•	Air For	ce?Civil	Serv. Name (First, Middl		ernment Sumame)	
narked natic ev		Joseph LaValle	10			Lill		llion		
aith and 27 le n er treun		19a. Informant's Name/Relationship <i>(Type, Print)</i> Pauline J. LaValle (Wi	fe) 601	Mailin 14	g Address <i>(Str</i> e Summerh	ill Rd.	Rural Route Num. Temple E:	ills,	MD 207	Zip Code) 74.8
nt of He : If item r or othe		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal for	om State 20b. Place of cemetery	Dispo	sition (Name of natory or other p Nation	_{lace)} Ja:	n . ^{Date} 3 , 2006		ocation - City o	Town, State Virginia
Departmentmontent importent eny injury once.	I	4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	111111111111111111111111111111111111111	22	. Name and Add	lress of Facility	ee Funera	al ho	me, Inc	
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certificate har	20	25. Was case referred to medical				26 Place of I	1 ☐ Yes	2 A No	1 ☐ Ye	s 2[X No
this aldi		examiner? 1 ☐ Yes 2 ▼ No 27. Manner of Death 1 ▼ Natural 5 ☐ Pending	☐ Inpatient 2 Tex ER/Outpate of Injury Month, Day Year) 28b. Ti		28c. In	other: 4 Nursing	g Home 5 Res 28d. Describe	idence		ecify)
by the	ermeanon	3 Suicide 6 Could not be 28e. P	lace of Injury - At home, fare uilding, etc. <i>(Specify)</i>	m, str		□Yes 2□No e		(Street ar. own, State		lural Route Number,
Funer ely fill	edical	29a. Certifier (Check only one) X Certifying Physician: To 2 Medical Examiner: On the and it	the best of my knowledge, ne basis of examination and manner stated.	death /or in	n occurred at the vestigation, in m	time, date and play opinion, death or	ace, and due to the courred at the time	cause(s)) and manner a d place, and du	s stated. e to the cause(s)
E 0 0	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Da	te signed (Mon	th, Day, Year)
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		30. Name and address of person who completed PATRICK B. MONAHAN, MA				RIMETER	RD ANDREI	JS AT	7В. МП °	20762
State Registra		PATRICK B. MONAHAN, MA 31. Date filed (Month, Day, Year) DEC 1 3 2005	J, USAF, MC 2. Régistrar's Signature			RIMETER	RD ANDRE	JS AI	B, MD	20762

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/Medi Examir	-2	4a.	Facility Name (I	f not institution, giv		umber)				Location of Dea							
- A				aris Hosp		1 - 4 0			oniu or 1 Year	M If Under 24 Hr		Baltimore					
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id be filed within 72 hours a ental Hygiene. ked other than "natural; o ic svant. Its Mudical Exam.	by Funeral	11	. Marital Status 1 ☐ Never Marri 3 🛣 Widowed	ed 2 Married	Armed F	: 2 [7]No Bive		was Dece If Yes, spe		ispanic Origin? (in, Mexican, Pue Specify:	Specify into Rica	Yes or No- in, etc.)		14. Race - Am Black, Wh Specify: W			
			(Spec	15. Decedent's E	ducation	1)	16a. Dece	dent's Usu	ual Occup	ation during most of w	orkina		16b. Kind of Business/Industry				
	Completed	_	Elementary/Seco			(1-4or 5+)	1	e kind of work done during most of work DO NOT use retired) aker			J. 11.17.9	1		Jun Homo			
	e Co	12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First,									Own Home						
	To B	-		 Brooks ame/Relationship (Type, Print)		19b. Maili	na Address	s (Street	Catheri			nond	-	Zip Code)		
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-		20	a. Method of Disp	osition Cremation 3	Removal from		Place of Dispo cemetery, crea	osition (Name	me of other plac	e)	Date		20c. Lo	cation - City o	r Town, State		
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DECEMBER 8, 2005 1:25 p.m.

FRANCES LUERS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** DECEMBER 8, 2005 EVELYN BERTHA LAPLANCHE 5:00 AM /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner WILLIAMSPORT WASHINGTON WILLIAMSPORT NURSING HOME If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Director 89 APR 15, 1916 MD 216.10.8191 Usuel Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be nuttined at 1 ☐ Yes 2 ☐ No Director WILLIAMSPORT WASHINGTON XX 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code ŏ Items 23a 21795 Completed by Funeral 154 N. ARTIZAN ST. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 ☐ No Specify: 3₩Widowed 4 Divorced WHITE XX Decedent's Usual Occupetion
 (Give kind of work done during most of working
 life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) permit. Pages 1 end 2 should be Department of Health end Mental important: If Item 27 is marked or ESTELLA G. NEALL HENRY PHILIP LANNATEWITZ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19408 JESWOOD DR. HAGERSTOWN MD 21740 MARY ESTELLE WAGNER DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) ò 3 Removal from State MEADOWRINGE CEMETERY 12.10.05 ELKRIDGE, MD of uneral Service Lice 21. Signal FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Exter the disease) or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. Hist only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical aspiration preumonio Examiner Due to (or as a consequence of edical Certification: To Be Completed by Physician/Medical Examiner dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) dementia Due to (or as a consequence of) cerebrovascular disease Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown OSTEOPOLOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Congestive heart Failure 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A efter 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier December 8,2005 D47451 Kutther - Sands mo Home, 154 North 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Nursing Home, 154 North Artizan Street, Williamsport Maryland 21795 Williamsport Cynthia Kuttner-Sands, MD 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signeture State Registrar 2005

			1 - For State Registrar	State of Ma	arylan		rtment <i>ificate</i>			nd Me	-	giene Reg. No		•	0.1	0.6
	Physici	an	negistrar Decedent's Name (First, Middle, La Damian Javis M				moure	, O, E	, outin		Date of De Month	ath Day	y Yea	r	3. Time of	
	/Medic	al	4a. Facility Name (If not institution, giv		<u> </u>		4b. City, T	own, or	Location o		DECEMI		11, 200 County of De	ath	8:30	P M
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ı	Funeral Director		212 30 0120	M 2□F	28	ast birthday) Yrs.	Months	Days	Hours	Min.	Date of Bird (Month, Da ugust	y. Year)	9. Birthplace (State or Foreign Country) 4,1977 Maryland			
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	with the h s or 28a-	Funeral Director	10e. Street and Number 4635 Shamrock	Avenue		10f. Zip Code 10 21 2 0 6						10g. Cit	0g. Citizen of What Country? USA			
	death rms 23	nerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. W	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puento				fy Yes or No	-	14. Race - An	nerican		
900	ges 1 and 2 should be filed within 72 hours atter death with the Marylend tt of Health and Mentat Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-1 ehow or other traumatic event, its Medical Examinar must be notified at	þ	XXX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	Yes 2. No Specify:							Black, Wi	Bla			
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212	filed with Hygiene. other than	Completed	Elementary/Secondary (0-12) 10th Grade	College (1-4or 5	s+)			bor	er				ty of	Ва	ltin	nore
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Jore	ages 1 nt of He : if Item		20a. Method of Disposition 1 ABurial 2 Cremation 3			lace of Disposi emetery, crema)	Dat 1 2 / 1			sdown			zlanć
Baltimore,	permit. Pages Department of Himportant; if Ite any injury or of once.		4 Donation 5 Other (Special 21. Signature of Fuperal Service Lice		IVI C •		Name and	d Address	s of Facility	Cha	tman-	Har	ris F	une	ral	Home
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99	ntificate ing phys s as the		IF FEMALE:	9												
.O. Box	s that the death certificat ned by the ettending phy of detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□E	Ectopic pre Other (spe				234			23d. Date of delivery Month Day Y		Year
Δ.	0 00	δ	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the und	derlying ca	use give	n in Part I.			obacco u	use contribute		cause of d	
Records,	ne law require hes been signed 2 should b	Completed									24a. Was autor		24b. Were prior to death	comp	findings	
Vital	iician: The l certificete he rector, page	Be Co	25. Was case referred to medical						26. Place	of Death (1 X Yes Check only o	2□No ne)	1/21	es 2[□ No	
of V	\$ 0 D	10 B	examiner? 1 XYes 2 □ No	L.,		ER/Outpatient			r. 4□Nu	rsing Home	5 ☐ Resid	dence	6XXXX ther (Sp	ecify)	SCE	NE .
ouo	ding Afte fune	tion;	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28	Sc. Injury Work 1 □ Y	at ? es 2 2 €1	1	d. Describe h	now injur	y occurred	lot		
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	3		30 Name and address of person who	completed cause of d	leath (Item			INT CIT	ਹ ਹ	י דאם	TTMODE	7.7.4	DVT AND	2	1 201	
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			1 - For State Registrar	State of M	arylan		ment of I	Health and Death	Mental Hy	giene Reg. No.	05	+0127		
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	Funeral Director			6. Sex. 7. AG	LCG 10 (In yrs. 1 64		Under 1 Year onths Days		8. Date of Bir (Month, Da	ay, Year)	9. Birth Cou Mar	WDEL place (State or Foreign intry) yland		
	ith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	10a. State 10b. County 10c. City, Town or Location										
	ath with the 23a or 28 unt be rist	ral Director	10e. Street and Number 558 Eason Road				Of. Zip Code 21144	4		-	10g. Citizen ol What Country? United States			
-	1215-0036 within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-1 show the Maryland Examine mast be recilised at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ▼Widowed 4 □ Divorced	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 No Army 1 Yes, Sive Year or Dates: Vietnam 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)										
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19	Maryland 2 d 2 should be filled h and Mental Hygis 7 is marked other traumatic event, it	To Be (17. Father's Name (First, Middle, I John T. McCarthy 19a. Informant's Name/Relationsh	y, Sr.		10h Mailing A	dd can (Cana	Geneviev	e Ruszk	(First, Middle, Maiden Surname) Ruszkiewicz Route Number, City or Town, State, Zip Code)				
£1.7	C, Ma 1 and 2 s Health ar am 27 is ther trau		John T. McCarthy 20a. Method of Disposition		20b. P	3 Andre	w Place	e Baltimo	re, Mary	yland	21201 tion - City or Te			
MS/4	Balthaor permit. Pages Department of Importent: If it any injury or o		1 Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Sign sure of Funeral Service L	ecify)			Mem. I	Pk. 12-1 ess of Facility Olyniak F tian Road		E1kri	dge, Ma	aryland		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the ettending physician and up to completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or burial-transit.	dical Examiner	23a. Part 1. Enter the disease or stock, or heart lajure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence	en. Do not enter the CM SA was a large at large	e mode ol dyi	hemorr	or respiratory a	rain I	usant	Approximate Interval Between Onset and Death		
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-	COLGS, F w requires that been signed b should be deta	by	Part II. Other significant condition	ns contributing to death b	ut not resu	ulting in the under	tying cause giv	ven in Part I.	23e. Did t			he cause of death?		
	VISION OF VITAL HECOFGS, Attending Physicien: The law requires to redath. ector: Affer this certificate has been signed by the funeral director, page 2 should be	Completed	25. Was case relerred to medical						1 ☐ Yes	psy prmed? 2 10 No	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of		
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	On of VIta ding Physicien: n. After this certific funeral director.		27. Manner of Death	28a. Date of Inju	rv	28b. Time of	28c. Injui Woi	4 Nursing H	ome 5 Resident			у)		
	TOISION I or Attendin efter death. Director: Aft	Certification;	1 Natural 5 Pending 2 Accident investig: 3 Suicide 6 Could n 4 Homicide determin	ation of be	ury - At ho	me, larm, street,	M 1 🗆	rk?]Yes 2□No	281. Location (City or Tox	Street and N wn, State)	lumber or Rura	al Roule Number,		
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	To COIT	¥	29b. Signature and title of certifier	1/2 On VIII	UD		29c. Licens		-	29d. Date s	igned (Month,	Day, Year)		
	101/		30. Name and address of person w	tho completed cause of d	eath (Item	23a) (Type, Prin		oxles 5	- د د د د د د د د د د د د د د د د د د د	Dec	ember	11 9007		
	10,1		Baltimore M	ashington	No	deal C	enter	301 H	tospital	Dr (Cleu E	Burnie MD		
	Sta Registr		31. Date liled (Month, Day, Year) DEC 1 3 2	305 Asia Registr	ar's Signat	ture Speak	2		U					

Scott Joseph McCreary Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23.b.PII, 28a-f.pen#E.632,2/6/06 II 05-08320 1- State of Maryland Department of Health and Mental Hygiene 1- State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 1 December 9 2005 10:40 P[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8702 Lock Bend Road Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Month, Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 10 M 2□ F 216-76-8829 Yrs. Director January 31,1958 Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or iteme 23a or 28a-f show vent. the Medical Examiner must be confided at 1 ☐ Yes 2 No Directo MO Jatimore Towson SUA the 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 8762 Boad 21234 end by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No. Specify: 3 ☐ Widowed 4 □ Qivorced Shite Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumarra) 17. Father's Name (First, Middle, Last) Be Mental ie marked ၉ Crawtord ces Neubauer George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lynn Beaty-Run, Hayes 20b. Place of Disposition (Name of cometery, crematory or other place) 7075 VICTORIA 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportant: if its eny injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 13 4 Donation 5 ☐ Other (Specify) Evans Fureral Chapel-Beltin 121 torest 21. Signature of Funeral Frysice Licensee 22. Name and Address of Facility EVans Chapel of M01220 Harturd Road Part: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Cardiac Arrhythmia /Medical Due to (or as a consequence of): Sevoflurane Toxicity Examiner Serofluranne Toxicity Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□ Unknown 9 Unknown s been signed to should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Cardiomegaly 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2☐ No 24a. Was an s certificete has l lirector, page 2 s 2□No 1 X Yes director. Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 100 ther (Specify) Scene Medical Certification: To 1XX es 2 □ No this After thi funeral 28a. Date of Injury Find 28b. Time of Find (Month, Day Year) Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.
neral Director: Aft 1 ☐ Yes 2 ▼ No 2 Accident 10:40 6 X Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8702 Lock Bend Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by determined 4 | Homicide Found at residence Towson, MD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**CXMedical Exeminer: On the basis of examination and/or investination, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of certifier 29c. License number OCME December 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIN mD 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

amend item 23b per me g878 4-15-08 vt

	1	For State Registrar	State of Maryla		partment of I ertificate of			e <u>p</u> e005	40129
Physiciar /Medica	n il —	Decedent's Name (First, Middle, Las	n McKin	ney			2. Date of Death Month December	Day 10, 2005	3. Time of Death 9:30am M
Examine	r 4	a. Facility Name (<i>If not institution</i> , <i>give</i> Greater Baltimore	1	4c. County of Death Baltimore					
Funeral Director		Social Security Number 6. S		s. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,)		thplace (State or Foreign puntry)
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with the Marylar to 28e-1 show be notified at	Direct	0e. Street and Number	more !	1.	Tows	1201	100	g. Citizen of What Co	
1215-0036 within 72 hours after death with the Maryland ans. then "naturel", or items 23s or 28s-1 show the Madical Exeminational Director	Funeral Director	1. Marital Status	12. Was Decedent Ever in Armed Forces?	1e u.s. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
OO36 OO36 urel: or life ample	2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 TNo If Yes, Give Year or Dates:		1□Yes 2 No			Specify: W/	ite.
within 72 ine.	Сотріете	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	16a. De	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of wor ed)	king	Sb. Kind of Business	/Industry
be filed votal Hygis do other the event, in	0 1 0 1	7. Father's Name (First, Middle, Last)	1	1 /1	OTKLIKAT	18. Mother's Nan	ne (First, Middle, Ma	WII NOK aiden Sumame)	1
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Baltimore, Sentil Pages 1 a Department of Her Important: if item my injury or othe		1 ☐ Burial 2 ∰ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Fuc	cemetery, c	position (Name of rematory or other blanch of Nat	16/1- 12/	11 /05 1	Forest H	II, MD
Balt permit. Departimentimporti	2	21. Signature of Funeral Service Licen	- Zachotky		22. Name and Adm	ess of Facility RK	RP TIM		ND 21093 NEMATI DNCE
Physician	- 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only mmediate Cause (Final	plications that caused the de one cause on each line	ath. Do not e	enter the mode of dy	ing, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death/
/Medical Examiner	1	disease or condition esulting in death)	Due to (or as a conse	equence of):	ng C	WYCOL			3 Minths
executed in and intransit	niner	Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause Cause (Disease or injury hat initiated events	b. Due to (or as a conse	equence of):					
68760, fificate be executed g physicien and as the buriat-transit	ו מ	hat initiated events esulting in death) Last	Due to (or as a conse	equence of):					
c 68760 ortificate be ing physicie e as the bur	Medic	F FEMALE:	d						
Division of Vital Records, P.O. Box 68760, Completely filled in by the funeral director. After this cartificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification. To Re Completed by Physician Medical Certification.	ysiciany	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	B Ectopic pregnand Other (specify)	sy		23d. Date of del Month	ivery Day Year
Cords, P w requires that been signed t should be deti	P P P	art II. Other significant conditions of	entributing to death but not re			ven in Part I.	23e. Did toba	_	the cause of death?
Vital Record siclen: The law requires to certificate has been sirector, page 2 should be Recommeted.	- ombie		prior to death?	utopsy findings available completion of cause of					
of Vita hysicien: his certific	2	5. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 Inpatient 2	□ ER/Outpat	ent 3 DOA		th (Check only one)	ce 6 Other (Spec	- 6.1
On of oding Phy th. There this funeral of tuneral of tu		7. Manner of Death 1. Datural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		of 28c. Inju	4 🗆 Nutsing H	28d. Describe how		city)
Division c	ertilice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, cify)	street, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ural Route Number,
Division To the Hospitel or Attentiviting 24 hours effer death To the Funerel Director: completely filled in by the		9a. Certifier Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my ki niner: On the basis of exami and manner stated.	nowledge, de nation and/or	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To th within To the compl	2	9b. Signature and title of certifier	land mo).	29c. Licen	se number 30929	29d	1. Date signed (Monti	h. Day, Year)
10	3	Name and address of person who o	completed cause of death (It	em 23a) (Typ	Charles &	ST, BA	mal	MD 21	284
State Registrar	~	11. Date filed (Month, Day, Year) DEC 1 3 2	32. Hegistrar's Sign	nature	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend item #8 per fh g850 122/116465 off Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11, 2005 December 03:00 a^M Hildegard Marie Martin 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson 1545 Cottage Lane If Under 1 Year ff Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Months 1 ☐ M 2 🔀 F 83 1922 213-38-8014 Germany Usual Residence of Decedent July 10c. City, Town or Location 10d. fnside City Limits 10b. County 1 ☐ Yes 2X No Towson Baltimore Md. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 1545 Cottage Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Colfege (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Unknown August Borner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1545 Cottage Lane Towson, Md. 21286 19a. Informant's Name/Relationship (Type, Print) 1545 Cottage Lane Towson, Md. Mr. Charles A. Martin/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 12-15-05 Timonium, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Fervide Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28e-1 show ery injury or other treumatic event, the Marinal Examiner must he agree.

Baltimore, Maryland 21215-0036

il Hygene.
I other then "natural", or Items 23s or 255 - 1 other then "natural", or Items 23s or 255 - 1 other the Mydical Executer must be natilised at

Completed by Funeral Director

Be

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Examine the attending physician and hed for use as the burial-transit requires that the death certificate be executed Physician/Medical t signed by the by Completed this certificate has : After this certification, I Physician: Certification: To the Hospital or Attending F within 24 hours after death, To the Funeral Director: After filled in by the

Records, P.O. Box 68760,

Division of Vital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown examiner' 1 Yes 2 No

2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one)

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending

investigation 6 ☐ Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 1)20649 29d, Date signed (Month, Dev. Year) 12/05

od address of person who completed cause of death (ftem 23a) (Type, Print)

John H. Bowie, MD 6701 N. Charles St. Baltimore, Md. 21204

State Registrar

0

Medical

31. Date filed (Month, Day, Year)

2005

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Voar **Physician** Kichard Joseph 4a. Facility Name (If not institution, give street and number) December 5:15 AM 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore TVC Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland If Und or 1 Year Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 108 M 2□ F 83 Director 216-32-8112 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanthar must be notified at 1 Yes 2 No Director Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 6718 Duluth Ave. death v Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 風Yes 2 □ No If Yes, Give Year or Dates: ₩₩ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after took of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itel 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 INO Specify: Specify: White β 3 ☐ Widowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Baker Bakery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marciana Ratajczak Joseph Mikulski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
sny injury or other trau 6718 Duluth Ave. Baltimore, Md. 21222 Patricia Mikulski Daug. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Ceme. 12/13/05 Dundalk, Md. A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic issee Kaczorowski Funeral Home P.A. 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or comshock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE **Physician** a END EMENTIA disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of Examiner ascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner equires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; Physician/Medical as the l IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9□ Unknown 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ed bluods hemi paveris 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 2XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/05 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud. Batto, MD 21218 29100 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mantel Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be notified at

Funeral Director

Be Completed by

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	Plea	se Type or	Print in E	Black I	ndelible	e Ink.	Assu	ıre Al	I Copies	Are Le	egible.			
		State	of Marylan						lental Hy	gierie)5	401	32	
				C	ertificat	te of L	Death			Reg. No.				
1. Decedent's Nam	e (First, Middle	e, Last)							2. Date of De Month	eeth Day	Yea		me of Death	
TORI N	400RE								DECEN	,	5, 200	5 2	300 PII	
4e Fecility Neme (If not institution	n, give street and nu	ımber)			4	b. City, To	wn, or Lo	cation of Deet	th 4c. Co	unty of De	ath		
Sinai 1	405pi	+a-1				1	Balt	in	ork		N/A			
5. Social Security N		6. Sex 1 □ M 2 □ F	7. Age (In yrs.	la <i>st birthda</i> Yrs.	Months	r 1 Year Days 5	if Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 11-1-	rth ay, Year) -2005		irthplace (S Country) RYLAN	State or Foreign	
Usuel Residence o	f Decedent													
10a. State	10b. County		10c. Cit	y, Town or	Location								ide City Limits	
MD.	N/A		ALTIM	ORE							15	Yes 2□No		
10e. Street end Nu						p Code				10g. Citizer	of What (Country?		
715 W.	LEXIN	GTON ST.				21201				US	SA			
	DESTIN		edent Ever in U	S 1				igin? (Sn	ecify Ves or N			nerican Indi	an.	
11. Maritel Status 12. Never Marr		Armed F	orces?	,5.	If Yes, spe	cify Cuba	n, Mexicar	, Puerto	ecify Yes or No Rican, etc.)		Black, Wh			
3 ☐ Widowed		If Yes. G	ive		1□ Yes	2Ã No	Specify:			Sp	ecify:	BLACK		
(Sne	15. Deceden	t's Education st grade completed)	16a. De	cedent's Usu	al Occupa	ation during mos	t of work	ina	16b. Kind	of Busines	s/Industry		
Elementary/Seco			1-4or 5+)	life	NFANT	ise retired)		9					
17. Father's Name	(First, Middle,	Last)					18. Mothe	r's Nam	e (First, Middle	, Maiden Su	mame)			
JOHNNY	Y NEAL						API	RIL	MOORE					
19a. Informent's N APRIL		hip <i>(Type, Print)</i> MOTHER)			-				BALTIM					
4 Donation	Cremation 5 Other (S		State KI	ng ME	sposition (Na crematory or CMORIAI	other plac L PAR	K			05 BAI	LTIMO		ARYLAND	
1	rath	Licensee JONAT	JuBre)	1721-2	27 N.	MONI	ROE S		TIMORI		•	A. D 21217	
23a. Part1. There shock, or hea	the diseese, or art failure. List	complications that only one cause on				de of dyin	g, such as	cardiac	or respiratory a	arrest,		Interv	eximate al Between t end Death	
Immediate Ceuse disease or condition resulting in death)	on	a. OVE	-whele Due to (corotiz	min	3 58	psi	5					2	days	
		b. NEC	rotiz	ing	Ent	-Ero	CO1	i+i	5			12	days	
Sequentially list co if eny, leading to in cause. Enter Und	mmediate erlying		Due to (c	r as a con	sequence of)	:	fa	ilo	~ 5				,	
Cause (Disease of that initieted event resulting in death)	s	c. CUI	Due to (o	r as e cons	sequence of)		fa					!		
		d										1		
Part II. Other signi	ficant condition	ons contributing to	death but not res	ulting in th	e underlying	cause give	en in Part I	l		L.	>	re to the ca	ause of death?	
									24a. Was	s an autopsy ormed?	24	available	on of cause	
									10	Yes 2.1	No.	1 ☐ Yes	2 No	
25. Was case refe	rred to medica						26 Plans	e of Deat	h (Check only	one)			,	
examiner?	No	Hospital: (Inpatient 2	ER/Outpa	itient 3 D	OA Oth	or.	11:	ome 5 Res]Other (S _i	pecify)		
27. Manner of Dee	å 5 □ Pendir	/4/0	of Injury onth, Day Year)	28b. Tim Inju	e of ry	28c. Injury Work	y at k?	Na	28d. Describe	how injury o	ccurred			

Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificeta be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physicien and completaly filled in by the funerel director, page 2 should be datached for use as the buriel-transit

Physician

/Medical Examiner

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Homa Niknafs m.D 31. Date filed (Month, Day, Year) State Registrar DEC 13

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 THomicide

Medicai Certification: To

29c. License number 00037630

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

1 🗌 Yes

2 No

29d. Date signed (Month, Day, Year) DECEMBER 5, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

Sinai Hospital 2401 W. BELVEDETE AVE Baltimore, Md 21215

22. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 5 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2005 **Physician** Dec. 8, 4:50 p^M <u> Albert J. Nowakowski</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 318 S. Macon Street Baltimore n/a 8. Date of Birth (Month, Day, Year) 6/28/24 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□F Months Days Hours Yrs. 81 Maryland 202-16-9425 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 ☐ No Director Baltimore Md n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 USA Macon Street 318 S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 Wildowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 0 Opitcal <u>Optician</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Cudnik Frank Cudnik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Michael Nowakowski 318 S. Macon Street Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 12/12/05 Baltimore, Md. St. Stanislaus 21. Signature of Funeral Service Licensee Kaczorowskiielluneral Home P.A. Dundalk Ave. Baltimore, Md. 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician /Medical Due to (or as a consequence of): ardiorascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☒ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 € No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner The taw requires that the death certificate be executed use as the burial-transit P.O. Box 68760, ó detached Records, page of Vital or Attending Physicien: this Division within 24 hours after death.

To the Funerel Director: A completely filled in by the fi

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Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If item 27 is marked other thar ury or other traumatic event.

death

filed within 72 hours after

Maryland 21215-0036

Baltimore,

other traumatic event, the Medical Examiner must be notified at

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

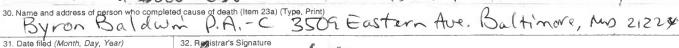
State Registrar

31. Date filed (Month, Day, Year)

DEC 1

3 2005

Durid



î 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

400 43 234

29d. Date signed (Month, Day, Year)

December 09,2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Frances Eleanora Narutowicz December 9, 2005 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bel Air 234 Vale Road Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕅 F Director 219-22-7389 98 26. 1907 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits Itams 23a or 28a-f ehow 1 ☐ Yes 2 No **Funeral Director** Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 Vale Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic avant, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Completed by 3 DWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked of Pages 1 and 2 should be Joseph Stephan Wesolowski Maryanna (nmn) Jakabiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germaine M. Vadas / Daughter f Health 234 Vale Road, Bel Air, Maryland 21014 othar 1 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation C ☐ Other (Specify) 70 permit. Page Department o Important: If any injury or once. = 5 Sacred Heart of Jesus 12-12-05 4 Donation Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Infarct week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 mor Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 2 400 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending after death. investigation 1 TYes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hc To tha Fun completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 135012 December 11, 2005

DHMH 17 Rev 1/2001

D

State

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

2 North Ave Bel Air, Md. 21014

o completed cause of death (Item 23a) (Type, Print)

32. A gistrar's Signature

LYNCH

DEC 1 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 1- For Amend item 20b per fh G850 12 Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Pecember 8,2005 terson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner DUI ore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 9. Birthplace (State or Foreign 7. Age (in yrs. last birthday) If Under 1 5. Social Security Number 6. Sex **Funeral** Days Year Months 219-62-219 1 M 2 □ F Maryland Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No paltimore Director Marylana 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number tems 23e or 212 800 OU Funerai filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner of 1 ☐ Yes 270 No If Yes, Give Year or Dates: 1 Never Married 2 Married ö 1 Yes 20 No Baltimore, Maryland 21215-0036 Specify. Blac δ 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than 's any injury or other treumetic event, ILe Magning. Elementary/Secondary (0-12) College (1-4or 5+) river 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be VVNITE Kobe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) , Wi te) 1800 Bever 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12-19-05 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cremator 21. Signature of Funeral Service Dicensee 22. Name and Address of Famility Stuneral H Ave. Balto. Home, P.H. D. Ma. 21216 23a. Part I There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) deseas Lives Physician /Medical Due to (or as a consequence a) Examiner OU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributifig to death but not resulting in the underlying cause given in Part I. à funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4-☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funerel Direct completely filled in by 4 | Homicide o the Hospitel 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 821 N. Eulaw 87 AHMED

State Registrar

31. Date filed (Month, Day, Year) 3 2005

State of Maryland / Department of Health and Mental Hygipne () 5 1 - For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11 2005 Physician December 7:54P Pumphrey Louise Genevieve /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena 8305 Ritchie Hwy. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 28 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min. 212-05-8944 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28s-f show the Medical Exeminar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Pasadena Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA 8305 Ritchie Hwy. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter nent of Heelih and Mental Hygiene. ant: It item 27 is marked other than "naturat", or ite ury or other traumatic event. It is Medical Exercite ury or other traumatic event. It is Medical Exercite 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No Specify: ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Household Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Cecelia Scharf Cooper Paul Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) daughter 8305 Ritchie Hwy. Pasadena, MD 21122 Nancy Ventura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any njury or once. Glen Haven Cemetery | 12/14/2005 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fire eral Service License e 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena Maryland 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the lused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lack line. Immediate Cause (Final disease or condition resulting in death) Pnysician cenyaration well /Medical Due to (or as a consequence of) dysfunction of Malabsorphion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit ementia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗌 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cete has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 28 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 I tnpatient 2 ER/Outpatient 3 DOA After this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Naturaf 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours af To the Funeral D completely filled i Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1) 40904 Cember 12, 2005 Wella-Hug MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1209 A Marda Lane Annapolis, MD 21403 Nancy D. River King M.D. 31. Date filed (Month, Day, Year) DEC 1 3 2005 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2005 Year Dec J. Peterson 7:42 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Nov 22, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 2 □ F 201 07 2159 Chester, Pa Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "netural", or iteme 23s or 28s-f ehow the Medical Examiner coust be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 77 Edward Drive United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Korean _{1□Yes} 2□No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ges 1 end 2 should be filed within of Health and Mental Hygiene. U.S. Army Captain Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Maher Carl Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Lorraine Peterson (wife) 77 Edward Lane, Lothian, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important: if ite
eny injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 8, 2005 Lee Crematory Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, loading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use es the the attending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No Insufficiency 3 ☐ Probably 4 ဩthknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? XX No 1 Yes 2 No 1 Yes within 24 hours effer death.

To the Funeral Director: Affer this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo MInpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46478 Dec 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh A. Patel, M.D. 7501 Surratts Rd, Clinton, MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 3 2005 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

2005

DECEMBER

ELGA PARKER

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiana 🕦 51 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 152 **Physician** 11,2005 ecember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and num Examiner 8. Date of Birth Dec. 22, 1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Maryland 64 218-36-6460 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State ı ıs marked othar than "natural", or Items 23s or 28a-1 show traumatic event, the Medical Evanimet mat be traffiled at 1 ☐ Yes 2 ☑ No Director Anne Arundel Curtis Bay 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 929 Chestnut Manor Court 21226 USA Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 __Wes 2 __ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 9002. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Plank Dorothea Lacher Herbert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Marguerite A. Plank</u> 929 Chestnut Manor Court; Curtis Bay, MD 21226 wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 12/16/05 Towson, MD 21. Signature f Hun and Selvice Licen 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List onty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician -4 wells /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and Box 68760, leretic Cardie Vascular disease Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, vase. pheral 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attanding Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient s after death, Il Director: After this of in by the funeral d 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and ad ss of person who impleted cause of death (Item 23a) (Type, Print) 3001 8. Hansver St. Balt. Md 21773 1110 E 31. Date filed (Month, Day, Year) 32 Registrar's Signature

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ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryland / Dep.	artment of Health and M <i>rtificate of Death</i>	lental Hygier	UUD 40141
			1. Decedent's Name (First, Middle, Last	}		2. Date of Death	3. Time of Death
	Physici /Medio		Catherine P	arson		Deem se	Day Year 1130 AM
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death
di			Genesis Homewood	Nursea Garage	Baltimore		Baltimore
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye.	20011111101
	Director		220-14-7612 16	M 2017 8/ Yrs.	Months Days Hours Min.	Scatember 2	4 1924 Country) MD
	D		Usual Residence of Decedent				11121
	how	_	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-fs	cto	MD Baltin	nore Touso	N		1 ☐ Yes 2 ☑ Ño
	or 28	Director	10e. Street and Number	2	10f. Zip Code	10g.	Citizen of What Country?
	238 as the wi	aic	7925 Vark 1	₹d	21212		USA
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
ဖွ	after or Ita	E	1 Never Married 2 Married	1 ☐ Yes 2 TVNo	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
8	ral.	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Exart and attentional to Indilled at	Completed	15. Decedent's Edu (Specify only highest grad		dent's Usual Occupation	16b.	Kind of Business/Industry
2	thin e	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)		0
2	filed with Hygiene. Ither thai	5	12		Clerk	54	tate of Maryland
b	be file ital Hy id oth avant	Be (17. Father's Name (First, Middle Last)		18. Mother's Name	(First, Middle, Maid	en Sumame)
<u>a</u>	ould be Mental sarked o	Tof	Kobert tars	50N	Elsie	Hausen	e.
Maryland	2 should I and Meni Is marker		19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or Rura	al Route Number, City	y or Town, State, Zip Code)
	1 and 2 Health a am 27 is		Michael Sidle Esa	- Personal 9513	5 Deerco Rd Suite	: 902, TIMON	Juan m) 21093
Baltimore,	s 1 a f Hei itam othe		20a. Method of Disposition	20b. Place of Dispo			Location - City or Town, State
5	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		10- 12	W. m
₽			21. Signature of Funeral Service Licens	BB 23	Name and Address of Facility	$\eta = \alpha$	HAMORE, 111D
Ba	permit. Departr Imports any inju		14/1/1	7 222 11/15	al Nome, P.A.		
			23a Part 1. Enter the disease or compl	ications that caused the death. Do not ent	2. Name and Address of Facility Bradley - M Show Bradley - M Sho	SPring A	2d. 21222
			snock, or neart failure. List only of	ne cause on each line		respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Endstoc	je Dementin		Onder and Boam
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	9		
	- Addining		Sequentially list conditions, if any, leading to immediate	o			
	Sit 3d	ine	cause. Enter Underlying	Due to (or as a consequence of):			
	ecute and trans	Examiner	Cause (Disease or Injury) that initiated events resulting in death) Last	s			
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68760	licate be executed physician and s the burial-transit	edical		d			
-	- m		IF FEMALE:				
Вох	leath certifi attending i for use as	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	Į.	23d. Date of delivery
	dea he att	Sici	in the past 12 months? 1 ☐ Yes S☐No		Other (specify)		Month Day Year
P.0	at the by the tach	hy	9 🗆 Unknown	3C OTKTOWN		-	
	law requires that the death certi as been signed by the attending 2 should be detached for use a	by F	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	w require been sig should b					1 🗆 Yes	2 No 3 Probably 4 dinknown
Vital Records,	aw re	ompieted				24a. Was an	24b. Were autopsy findings available
Re	9 4 9	mc.				autopsy performed?	prior to completion of cause of death?
E	ician: Th certificate rector, pag	Ö	25. Was case referred to medical			1□ Yes 2□A	lo 1 Yes 2 No
5		0 0	examiner?	lospital:	26. Place of Death		
o	Physical distribution	\vdash	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of	IT 3 DOA 4 DOURSING HON	ne 5 ∐ Residence 28d. Describe how inj	6 Other (Specify)
On	ding Ph th. After th funeral	tion	1 Natural 5 ☐ Pending	(Month, Day Year) Injury	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	od. Describe now in	ary occurred
Division	or Attending after death. Diractor: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, stre		Of Location (Street	and Number or Rural Route Number,
<u>></u>	after Dira	erti	4 Homicide determined	building, etc. (Specify)	eet, ractory, office	City or Town, Sta	
_	pital purs eral filled	Ö	29a, Certifier 1 Certifying Phys	ijojon. To the best of my leaveled as death			
	To the Hospital or Attan within 24 hours after deat To the Funeral Diractor: completely filled in by the	edical	(Check only 2 Medical Examile one)	sician: To the best of my knowledge, death	n occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the cause(ad at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of of rtifier	and manner stated.	29c. License number		
	To Too		S. Signaturo and Mile of Artificial			29d. D	ate signed (Month, Day, Year)
	,		/ Many	Just .	D0059423	De	cember 9, 2005
	6		30. Name and address of person who co	mpletes cause of death (Item 23a) (Type,	Print)	~	
	9		Ndidi Femberg G	Sol Samaritan Hospi	Print) tal Print Building #3	303 Belton	more, MD 21239
* *\$	Sta		31. Date filed (Month, Day, Year)	2005 32. Registrar's Signature	boarde		•
	Registr	ar	カドカ エ の	LOUD PARTIES OF			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** rechoc ertha 1300M 2005 /Medical Facility Name (If not institution, give street and number) 4c. County of Death or Location of Death Examiner Baltimore Bay view Care Center Johns Hopkins n/a If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F 95 212-20-0296 Director 8/6/10 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d, toside City Limits 1 Yes 2 No by Funeral Director Dunda1k Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 210 Maple Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3. Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Fidelity Deposit 4 Chairwoman traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joanna Kleheimer Ignatius Antczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is / injury or other trat. Baltimore, Md. 21222 Maple Ave. Dorothy Valonis 210 Mrs. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. 12/15/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Stanislaus 21. Signature of Funeral Service License Kaczorowski Fartuneral Home P.A. Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death erebrovascular **Physician** ear: disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Fo the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2005 who completed cause of death (Item 23a) (Type, Print) For Kin Boyye Circle Balt Be 503 Michele 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:31 AM DECEMBER 2005 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 9 F 220-70-1573 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Tyes 2 THO Director BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 21800 or itame 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE *natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.

7 le marked other then "n College (1-4or 5+) Elementary/Secondary (0-12) ERINARIAN ANIMAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a CATONSVILLE, MD ROBERT MEISENHELDER/SPOUSE 5 BALLYMENA (91998 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ANATOMY GIFTS REG 4 Donation 5 ☐ Other (Specify) HANOVER, MI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 15 Ca MATTONYGIFTS PISCUSTRY 7522 COINCILLEY DT, HANCUR MD DIOTE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SALCOMA **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in reclait cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LOST, Tacquetine 12-9-05 063, Due to for as a consequence of Examiner After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□No 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Sother (Specify Wispec) Hospital 1 ☐ Yes 2 Ø No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral DI 29a. Certifier 🛩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) December 9 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONION, MO Comicis Chronly 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State State Pegistrar For State Pegistrar For Registrar	of Maryland / Department of Health and Menta FH, G851, 01/18/100db	Hygiene 05 L	01	L, L,
Pacadent's Nama (First Middle Last)	2 Date	of Death	2 Ti-	(Daa

Physicia /Medic Examin

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28e-f ehow eny Injury or other traumatic event, Ira Mudical Examinar must be notified at QDC8. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Atlending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name	(First, Middle	Last)			, , , , , , , , , , , , , , , , , , ,		2. Date of D	eath			3. Time of Death	_	
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al er	4a. Fecility Name (If			mber)		4b. City, Town,	or Location of Dea		-	c. County of		10.14 a.		
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_	5. S214eckiy N		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	N/A). Birthpl	ace (State or Foreign		
	214-64-	8397	1 ∑ M 2□F	4	9 Yrs.	Months Days	Hours Min	. (Month, D			Count M A D	YLAND		
	Usual Residence of					4		1 0 3 / 2				IDAND	_	
_	10a. State	10b. County	12	10c. Ci	ty, Town or Lo						10	Od. Inside City Limits		
cto	MD	IN ,	/ A		BALT:	IMORE C	ITY					X□Yes 2□No		
Oire	10e. Street and Num					10f. Zip Code			10g. C	itizen of Wha	at Count	try?		
<u>=</u>	5024	DENMO	RE AVENU	JE		21:	215		Ţ	USA				
Inel	11. Marital Status		12. Was Dec	edent Ever in U		Was Decedent of I	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note Rican, etc.)	0-	14. Race -	America White, e	an Indian,		
ΥF	1 Never Marrie	2.5	If Yes, G	ve 27	1	1 ☐ Yes 2 🙀 No	Specify:			Specify:				
ð D	3 Widowed		Year or E	ates:		21			1			ACK		
Completed by Funeral Director	(Speci	15. Decedent' ify only highes	s Education grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking	16b.	Kind of Busin	ness/Ind	lustry		
Ē	Elementary/Secor	ndary (0-12)	College (1-4or 5+)		E FITTE				CONST	RUC	TION		
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ို	19a. Informant's Na		·		10h Mailir	ng Address (Street				or Tourn Str	ato Zio	Codol		
	MYRTLE		, , , ,	WIFE		-						,		
	20a. Method of Disp		INDOON /	20b.	SU 2	24 DENMO		Date BE	20G-1	Pton - Cit	ty or Tox	21215 wn. State	-	
	1 ⊠ Burial 2 ☐ 4 ☐ Donation		3 Removal from	State WI	STERN		EM. 12	/17/05		TONS				
b	21. Signature				22	2. Name and Addre							-	
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	shock, or hear Immediate Cause (I	tranjere. List o	only one cause on	sach line.								Interval Between Onset and Death		
	disease condition resulting in death)	n				rosclero	tic Cardi	iovascul	ar I	Diseas	е			
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an/Medical	.=													
) L	IF FEMALE: 23b. Was decedent			tcome of pregna		JEctopic pregnanc	,			23d. Date o	of deliver	delivery		
	in the past 12 a			ant at time of d		Other (specify)	'			Month	C	Day Year		
by Physic	9 ☐ Unknown												_	
þ	Part II. Other signifi			eath but not res	ulting in the u	nderlying cause gr	en in Part I.	23e. Did			ite to the	e cause of death?		
Completed	Chronic	Alcoho	lism					1 🗆	Yes 2	15 on 3] Proba	ably 4 Unknown		
ble								24a. Was	an	24b. Wer	re autop	sy findings available		
Ö								perfe	rmed? 2□N	dea dea	gth?	2□ No		
Bec	25. Was case referr	ed to medical	F				26. Place of De	ath Check only					-	
2	1 XYes 2 ☐ !	No	Hospital: 1 🗆	Inpatient 2/	ER/Outpatien	nt 3 DOA Ott	er: 4 🗌 Nursing I	Home 5 ☐ Resi	dence	6 □Other ((Specify))		
	27. Manner of Death	5 ☐ Pending	28a. Date (Mor	of Injury th, Day Year)	28b. Time of Injury	f 28c. Inju	y at k?	28d. Describe					-	
atte	2 Accident	investig	ation				Yes 2 □ No							
Ĕ	3 Suicide 4 Homicide	6 Could no determin	288. Place	of Injury - At he ing, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (City or To			or Rural	Route Number,		
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cal	29a Certifier (Check only	1 Cartifying 2 Medical E	Physician: To the backward of	asis of examina	wledge, death	business at the tile vestigation, in my o	ne, Jate and place pinion, death occi	e, and due to the urred at the time,	date ar	e) and manner of place, and	of as sta	ited. the cause(s)		
Medical Certification;	one) 29b. Signature and		and man	ner stated.		29c. Licens								
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	1 00 W	unec) sell	y ne	1						•			
	30 Name and addre	ess of person	no completed cau	death (Item	n 23a) (Type,	Print) 111 P	enn Stre	et Balt	imo	re, Ma	$_{ m ry}$ 1 $arepsilon$	and 21201		
	31. Date filed (Month	h. Day Yaar	TO LEGICAL	イック・ Registrar's Signa	ature								-	
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State

Registrar

April 1

			For Amend Item 1	State of Market Property	3850 1	2 Depa 2 Cer	utmen tificat	t of He	ealth a Death	nd Me	ntal Hy	giện Reg. No	9 ()	5 1	0145
	Physici		Decedent's Name (First, Middle, Last)	Doris Ca		ne Re	inha	rdt			Date of De Month	eath Da		Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of	Death	-	40	. Count	y ol Death	
		4 7 1	UNIVERSITY OF MA	RTLAND	MEDICA	L CENTE	R	B	ALTIM					N/	A
	Funeral Director		5. Social Security Number 6. Sex 215-14-9590		e (In yrs. las 32	st birthday) Yrs.	II Under Months	1 Year Days	If Under 2 Hours	4 Hrs. 8. Min.	Date of Bir (Month, Da 3-25-1	th ay, Year 923)	Cou	place (State or Foreign htty) land
	p .		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation								10d. Inside City Limits
	eho eho	ō.			l co. oity,	Balt									1 XYes 2 No
	28a-1	Director	Maryland n/a 10e. Street and Number			Dait	10f. Zig					10a. C	itizen ol	What Cou	ntry?
	Sa or		600 Light Apt.	804				212	30					State	
	hours after death with the Maryland turel', or Items 23a or 28a-f show at Exercit at must be notified at	Funerai		2. Was Decedent	Ever in U.S.	13. V	Vas Dece	dent of His	spanic Orig	in? (Specif	y Yes or No	o-			can Indian,
9	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 If Yes, Give			ires, spe I∐Yes		Specify:	Puerto nic	an, etc.)		Speci	ick, White	
93	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:										WIII	
5-	72	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced	lent's Usu kind of wo	al Occupa ork done d	tion uring most	of working		16b. i	Kind of E	Business/Ir	ndustry
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d 2	Hygie Hygie Sther ent, II		7 years 17. Father's Name (First, Middle, Last)			WEIG	.CI		18. Mother	's Name (F	irst, Middle				
an		To Be	James B Gover						Henre	tta Y	/ingli	ng			
Maryland 21215-0036	s 1 and 2 should Health and Meritem 27 is marks other traumatic		19a. Informant's Name/Relationship (Type	oe, Print)							loute Numb				
	and 2 salth a n 27 is		James Reinhardt	(son)					re. Ba	iltimo	ore, M	lary.	land	2121	
ore	000-		20a. Method of Disposition 1 k d Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cen	ce of Dispo: netery, cren	natory or o	other place		Date					own, State
Ë	Pages ment of lant: If it		4 ☐ Donation 5 ☐ Other (Specify)		Mary	land			-						e, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Foneral Service License	e Wavne Os	terlir		Cull SO E.	nd Address y—Po] Fort	s of Facility yniak : Ave	Fune Balt	eral H	Home	, P.	A. 1230	
	450 98.		23a Part1. Enter the disease, or compli- shock, or healt failure. List only on	cations that caused	the death.										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		RONA	RY	A	RTE	RY	DISE	ASE				Onset and Death
- 6c.	/Medical Examiner		resulting in death)	Due to (or as											10/13
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	ed sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	M. H		Λ								YEARS
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89	g phy as the	edic													
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	ne deat the att	sicia	in the past 12 months? 1 Pyes 2 MNo	4☐Pregnant a			Other (s						М	onth	Day Year
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	ires tha signed I be det	ρ	Part II. Other significant conditions cor	thouling to death i	out not result	ing in the ur	ngeriying (ause give	n in Parti.				use con	ore Sudding	the cause of death?
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Ξ	ysician: is certific director,	00	25. Was case referred to medical examiner?	ospital:	ent 2 TE	R/Outpatien	t 3 □ D	Othe			Check only 5 ☐ Resi		6 DO:	har (Cana	6.0
of	ng Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Inju	Jry 2	8b. Time of		28c. Injury Work			d. Describe				19)
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	ital or A irs after ral Directal														
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best ier: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred vestigation	at the tim	e, date and pinion, deatl	l place, and h occurred	d due to the at the time,	cause(: date ar	s) and m	anner as : , and due !	stated. to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	1			29	c. License	number			29d. D	ate sign	ed (Month,	Day, Year)
	, ,		> What Un	h r	1.0.			145	49			0 8	C.	8	2005
(_//		30. Name and address of person who co				Print)	-	* -						
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18	Sta Regist	ate rar	31. Date liled (Month, Day, Year) DEC 1 3 2	32. Regist	rar's Signatu	re	mesta	1							

			For State Registrar		aryland / [Depai Cert	rtment of H	lealth a <i>Death</i>	nd Mental Hy	Reg. No.		0146
	Physici		1. Decedent's Name (First, Middle, L Melvin F. Rol						2. Date of De Decemb		o, 2 00 5	3. Time of Death 10:32 A M
	/Medic Examin	45	4a. Facility Name (If not institution, given 2004 Carrs Mil	ve street and number)			4b. City, Town, or Falls		Death	4c.	County of Death Harfor	d
	Funeral Director		5. Social Security Number 6. 219–28–6294	Sex 1.XXM 2□F	o (In yrs. last bir 73		If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, D.	rth ay, <i>Year)</i>	9. Birthy Coul	place (State or Foreign ntry) 1and
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loca	ation	<u> </u>			1	IOd. Inside City Limits
	e Mary Sa-f sh	ctor	Maryland Harfor	d	Fallst	on						1 ☐ Yes A No
	th with th	Funeral Director	10e. Street and Number 2004 Carrs Mill	Road			10f. Zip Code	1047		10g. Citi	izen of What Coul	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Ever' it art and the notified at Once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba □ Yes 2 No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Wh	
21215-0036	"netur	Completed	15. Decedent's l (Specify only highest g	ducation rade completed)	16a	(Give k	ent's Usual Occup ind of work done	durina most	of working	16b. Ki	ind of Business/In	dustry
212	d withii glene. er than	omo	Elementary/Secondary (0-12)	College (1-4or 5	⁺⁾ P1	umbe					Plumbin	g
and	be file at othe event,	Be	17. Father's Name (First, Middle, Las						rs Name <i>(First, Middle</i> 111ie Dean	e, Maiden	Sumame)	
ar Žį	shoutd nd Mei marke umatic	2	Melvin W. Rohrba 19a. Informant's Name/Relationship		191	o. Mailing	Address (Street		r or Rural Route Numb	per, City o	or Town, State, Zip	Code)
, M	and 2 ealth a m 27 is		Melvin F. Rohrba	ck, Jr. Sc				Mi11	Road, Fall			
Baltimore, Maryland	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1X Paurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		remete	st Va		metery	Date 12/14/05	Mid		Maryland
Balt	permit Depart Import any inj once.		21. Sign 11 f Funeral Service Lic	arpenter		36 36	Name and Addre Irgee-Hei 31 Fall	ss of Facility nss-Se s Road	itz Funera , Baltimor	il Ho	me, Inc. Maryland	21211
			23a. Part1. Enter the disease, or co shock, or head ailure. List on	y one∦cause on each li≝	16.	/			/	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		on ges a consequence		? Heart	10	riore		/	5 years
o,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Eines Unideslying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence							
.O. Box 68760,	that the death certificate be ted by the attending physicin detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death		Ectopic pregnancy Other (specify) _	,			23d. Date of delive	ery Day Year
Δ.	es that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the un	derlying cause giv	ren in Part I.	23e. Did	tobacco	se contribute to t	he cause of death?
ord	requir een si nould								_			oably 4 □Unknown
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Vital	stcien: certific rector,	o Be (25. Was case referred to modical examiner?	Hospital:	ent 2 ER/O		aci pou Oth		of Death (Check only		0.000	
of	ig Phys ter this neral di	<u> </u>	27. Manner Peath	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Injur		28d. Describe			у)
Division	To the Hospitel or Attending i within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	on be Ose Blees of Ini	ury - At home, fa		M 1	Yes 2□N	28f. Location	(Street an	nd Number or Rura a)	al Route Number,
	To the Hospitel c within 24 hours af To the Funerel D completely filled in	ledical Ce	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	examination ar							
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6	2/1		30. Name and address of person who	o completed cause of d	leath (Item 23a)	(Type, F	erint)	Ste	Hor ton	Von	mp. 2	1204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signature							<u>.</u>
DH	IMH 17 Rev 1/2	-	Ut G L	3 2005	sun L	A. A.	JOENES -					
					ORI	GINÁ	L					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Edna M. D. Robinson December 10, 2005 5:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb 25 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 213-20-5737 92 Marviand Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23a or 28a-f show the Madical Examiner must be notified at Md.Baltimore Lutherville Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Charmuth Road 21093 USA filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed by 3 → Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personell Assistant Balt. Co. Board of Ed. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental H Birchman Donellan Emma Griffner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health an Mr. Bruce T. Robinson/ Son 103 Charmuth Rd. Lutherville, Md. 21093 permit. Pages 1 and Department of Health important: if item 27 any injury or other tr once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 12-14-05 Timonium, Md. ^{22. Name and Address of Facility} Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, Md. 212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVA **Physician** wole /Medical Due to (or as a consequence of): Examiner Sequentially list conditions is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? strokes, demention 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? (es 2 No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 1 ☐ Yes 2 📉 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 Tes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in To the Hospital ritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordan MD

32. Registrar's Signature DEC 1 3 2005

December 11, 2005

6565 N. Charles St Baltonano Mas 21204 Sparke

10051926

29c. License number

State of Maryland / Department of Health and Mental Hygrene () 5 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician RALPIT 12 2005 11:45 A^M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN BURNIE ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 11/21/1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min PENNSYLVANIA 78 Director 181-22-5278 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r than "natural", or iteme 23a or 28a-f shov the Medical Examiner rust by notified at 1 ☐ Yes 2 X No ANNE ARUNDEL GLEN BURNIE Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 104 FOREST STREET U.S.A. 21061 death 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1945–49 1 ☐ Yes 2X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONTRACT WORKER WESTINGHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event page. WILLIAM RALPH, SR. CATHERINE WEST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. BARBARA JEAN RALPH/WIFE 104 FOREST ST., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GLEN HAVEN MEM. PK. 12/13/05 GLEN BURNIE, MD 4 □ Donation 5 □ Other (Specify) 21. Signal ye 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) HELDSTATIC BLAMBIAN CANCIEN 412 Ans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Numberown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death I Diractor: A investigation 3 Suicide 6 Could not be within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifies 027838 d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STECHOE MANNIAD, LINITITICUS NO SHANENI, JOHN 7 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 3 2005 Coaste Registrar

		For State Registrar	State of Ma	ıryland	•			ealth a			giene	JUD	l,	0149
Physici	an	1. Decedent's Name (First, Middle, Las	Piley							2. Date of De Month	ath Da	7. 20		3. Time of Death 11 40 A M
/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	 		4b. City	, Town, or	Location	of Death	V CCC.		County of D		,
LAGITIM		University of Ma	ryland Mea			Ba		TORE						
Funeral Director			ex 7. Age XM 2□F	(In yrs. las 76	st birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da March	$\overset{th}{1}\overset{Year}{4}$	1929	Countr	ice (State or Foreign y) ryland
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ith the M or 28a-f	Funeral Director	MD Carrol 10e. Street and Number	. L		Manc		p Code				10g. Cit	izen of What	Countr	y?
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er dea	uner	11. Marital Status	12. Was Decedent E Armed Forces?		. 13.	Was Deci If Yes, sp	edent of Hi ecify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, V		
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Exerters must be notified at	by F	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	XXYes 2 N 1f Yes, Give Year or Dates:	Kore	a	1 🗆 Yes	X X No	Specify:				Specify:	Wh	ite
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Examiner by State be executed by State by State by Examiner and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute Due to (or as: C. Due to (or as: d.	Conseque	enter	y dr	91 res	9 97	indr	onie			2	2 wates
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		1/1/2	JIVIT -		00-1-7		11	860	0		VECC	riber	8,	2005
10		30. Name and address of person who	completed cause of d	eath (Item:	Goutl	, Print)	cene	5t,	Balt	Timer,	140	213	201	2005
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F	hysici /Medio		Decedent's Name (First, Middle MYRTLE RUSSE								2. Date of De Month	Dav	2 00 S	3. Time 7:11	of Death
	Examin		4a. Facility Name (If not institution KESWICK NURS		mber)		-		Location of MORE				inty of Death		
	ineral rector		5. Social Security Number 214-40-5269	6. Sex 1 ☐ M 2 🛱 F	7. Age (In yrs. Id 94	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5-23-	th Y, Year) I 911	9. Birthe Cour MARY	olace (State otry) LAND	e or Foreign
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ath with t	ust be n	rai Dir	10e. Street and Number 2300 MOSHER	ST.			10f. Zip	1216				10g. Citizen	of What Cour A	ntry?	
JUGO nours after de	rel', or items Examiner o	d by Funeral	11. Marital Status 1 ∰Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 DNo /e X		Was Deced fYes, spec 1 ☐ Yes 2	ify Cubar	spanic Orion, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	8	Race - Americ Black, White, ecify: BL		
IIIG KIKIDOOO be titled within 72 hours after death with the Maryland Ital Hygiene.	Important: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show eny injury or other treumatic svent, the Medical Examiner must be radified at ODGs.	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) —12—	t's Education at grade completed) College (1	-4or 5+)	(Give life. i	dent's Usua kind of wor DO NOT us ACHER	l Occupa k done d e retired)	tion uring most	of worki	ng		f Business/Ind		
ar yrand should be file and Mental Hy	arked othe atic svent,	To Be C	17. Father's Name (First, Middle, ABRAHAM L. RI								(First, Middle, WEST	Maiden Sum	ame)		
and 2 sho	n 27 is ma ier treuma		19a. Informant's Name/Relations SHAWN R. HERI	hip <i>(Type, Print)</i> BY, ESQ(GU		309	CONK	ING S	od Numbe ST. B	r or Rura ALTI	MORE, M	er, City or Tov IARYLAN	vn, State, Zip ND 2122	Code) 24	
mit. Pages 1	ant: If iter ury or oth		20a. Method of Disposition 1	3 □Removal from a	State ARB	ace of Dispo metery, cren UTUS 1	natory or ot IEMOR]	her place [AL]	PARK	12-1	ate 2-2005	BALTIM	n - City or To	ARYL.	AND
permit. Departn	Importa eny inji 2009		21. Signature of Funeral Service		AND. H	IBNER2	. Name and	Address	of Facility	PHI	LLIPS F T. BALT	'UNERAI	HOME.	P.A	
/Me	sician edical miner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. Eld.	aused the death ach line. 	- all	free mode		, such as o		r respiratory ar	rest,		Approximation Interval Biognoset and	etween d Death
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.	physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque										
the death certifi	ittending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnan inth 2 Fetel of ant at time of dea own	death 3□	Ectopic pre Other (spe						Date of delive Month	ry Day	Year
us, r	signed by the a	by	Part II. Other significant condition			ting in the ur	nderlying ca	use giver	n in Part I.		23e. Did to	bacco use co			
The law req	s certificate has been si irector, page 2 should	Completed		cular c	tih						24a. Was a autop perfor 1 Yes	sy	were autop prior to con death? 1 \(\text{Yes} \)	rpletion of	s available cause of
ending Physicienseth.	fter this ineral d	ation; To Be	25. Was case referred to medical examiner? 1	28a. Date of (Monti	The second second second second	P/Outpatient 28b. Time of Injury		Other c. Injury a Work?	4 DHI	sing Hon 2	(Check only or ne 5 ☐ Resid 8d. Describe h	ence 6 🗆 O)	
ital or Atter	al Durecto	Certification;	3 Suicide 6 Could r 4 Homicide determi	ned 28e. Place buildir	of Injury - At hon ng, etc. <i>(Specify)</i>						8f. Location (S City or Tow	n, State)			mber,
To the Hospital or Attendi	To the Funeral completely filled	Medical	one)	g Physician: To the Examiner: On the ba and mann	isis of examination	ledge, death on and/or inv	estigation, i	n my opii	nion, death	place, a occurre	nd due to the c d at the time, d	ause(s) and r late and place	manner as sta e, and due to	ited. the cause((s)
To	01 000	2	29b. Signature and title of certifier Multiple	Mac gre	gormo			License				9d. Date sign Cell			105
)			30. Name and address of person of 1 SAB GUE	MACRETE	1R, 70	0 W.	to th	STRE	EBT,	BA	1070/				
F	Stat Registra		31. Date filed (Month, Day, Year) DEC 1 3 200	32. Re	egistrar's Signatu	ire?	5								

			1 - For State Registrar	State of M	aryland	d / Depa		of H	ealth a					40151
г	Physici	ian	1. Decedent's Name (First, Middle	Last)							2. Date of De Month	Day		3. Time of Death
	/Medi Examir	cal	Betty 4a. Facility Name (If not institution,	ane	Seit	.Z	4b. City. T	Fown, or	Location o		Decembe		, 2005 County of Death	6:30 pm ^M
	Examin	ier På	Manor Care Heal				Ross						altimor	
T.	- Funeral Director		5. Social Security Number 191–12–8084 Usual Residence of Decedent	1 □ M 2 □ WE	e (In yrs. Ia 82	ast birthday) Yrs.	If Under 1 Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 2/28/	th ly, <i>Year)</i> 1923	9. Birth Cou Pen	place (State or Foreign intry) nsylvania
	yland		10a. State 10b. County		10c. City,	, Town or Lo	ocation							10d. Inside City Limits
	hours after death with the Maryland tural', or iteme 23s or 28s-f show al Exertiner must be notilised at	Director	Maryland Balti	more	Ess	ex				-				1 Yes 2 No
	with t	Dic	10e. Street and Number	d			10f. Zip (en of What Cou	intry?
	death	Funeral	167 Riverside F	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Decede		spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		S. A. 4. Race - Amer	
36	safter , or ite	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ⊡Yes 2 📆 If Yes, Give	No		1 ☐ Yes 2		Specify:	i, Fuelto	nicari, etc.)		Black, White Specify:	, etc.
21215-0036	d within 72 hours after death with the Marylar jene. Ir than "natural", or iteme 23a or 28a-f ehow I'te Medical Examiner must be notified at	ted b	15. Decedent'	Year or Dates: s Education		16a. Dece	dent's Usual	І Оссира	ition			16b. Kin	Wind of Business/Ir	hite ndustry
218	within 7 ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	kind of work DO NOT use	k done d e retired)	uring most	t of worki	ng			
d 2	Hyger art,		12 17. Father's Name (First, Middle, L	ast)		Ushe	r		18. Mothe	r's Name	(First, Middle		go Hall Sumame)	
/lan	ould be Mental varked c	To Be	Harry Irwir	Baldwi	n				Chri			anks	,	
Maryland	2 she and Is m		19a. Informant's Name/Relationsh								l Route Numbe	er, City or	Town, State, Zi	p Code)
	s 1 and if Health Itam 27 other tr		Margaret Jones 20a. Method of Disposition	(Daughter)	20b. Pla	ace of Dispo	River	e of			ssex, M		and 212 sation - City or T	
E O	Pages nent of int: If I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			•	natory or oth Cemet		1	12/1 2005				Maryland
Baltimore,	permit. Pages. Department of H Important: If Its any injury or ot		21. Signatur of Funeral Service L	censee		22	Name and Bruzdz	Addres	s of Facility	, nera	l Home	PA		land 21221
			28a. Part1. Enter the disease or c shock, or heart failure List of	omplications that caused not one cause on each lie	I the death.	Do not ent	er the mode	of dying						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	LUN		ANC	EX.						Onset and Death
	Examiner		O and the first and the	Due to (or as	a conseque	ence or):								
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as	a noneaque	enea offy								
,	te be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):								
68760,		cal	(d										
9 X	death certificat e attending phy id for use as th	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnan	cv								
P.O. Box	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pred Other (spec					23	3d. Date of deliv Month	ery Day Year
Division of Vital Records, P	The law requires that the tee bas been signed by the bage 2 should be detache	by	Part If. Other significant condition	s contributing to death b	ut not result	ting in the u	nderlying cau	use give	n in Part I.			obacco us		he cause of death?
eco	e law rec has bee je 2 sho	Completed									24a. Was	an	24b. Were auto	opsy findings available impletion of cause of
a B	r. The								_			rmed?	death? 1 ☐ Yes	
Ž	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2∏F	R/Outpatien	t 3 DOA	Cthe			(Check only o		☐Other (Specil	£.1
n of	ding Physician: The I h. After this certificate ha funeral director, page		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injur	ry 2	28b. Time of Injury		c. Injury Work	at		8d. Describe			y /
isio	Attending r death. ector: After by the funer	Icat	2 Accident investiga 3 Suicide 6 Could no	tion	unu At hom	20 form ste	M		es 2 N		106 Lanation (6	244	N	
ρ	al or A s after il Direction by	Certification:	4 Homicide determin	building, etc	: (Specify)	ne, iaim, str	eet, factory,	опісе		4	City or Tou		Number or Hura	al Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only gine)	Physician: To the best of xaminer: On the basis of and manner sta	examinatio	ledge, death on and/or inv	occurred at vestigation, in	t the time	e, date and inion, deatl	place, a	nd due to the old at the time,	cause(s) a date and p	and manner as solace, and due to	tated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title an certifier					License					signed (Month,	
·	01	2	30. Name and address of person w	M	onth /lt-= 1	32a) (T		006	2560		1	ECEN	MBER, 1	2,2005
-	U		PARIGAT KINETEN	gar 201,0	BACK	RIVER	NEL	12 6	-D.	#10	9 . 8	ALTI	more, 1	2,2005
The state of the s	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re E	backs	· ·						
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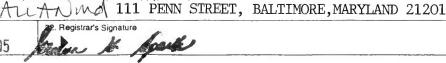
			For State Registrer	State of	Maryland / De	partment ertificate				giene 05	explained (1)	0152
	o Physici	an	Decedent's Name (First, Middle	,	•	C 1 - 1			2. Date of De Month	Day	Year	3. Time of Death 9.55 A M
	/Medic		4a. Facility Name (If not institution,	Virgi		Seidel	own, or Loc	cation of De	Decem	4c. County o	2005 f Death	7.33 / Т.
	Examin	er	Catonsville Co	-	,		atons				ltim	ore
	Funeral			6. Sex 7	7. Age (In yrs. last birthd	Months		Under 24 H	in. 8. Date of Bir	v. Year)	9. Birthp	lace (State or Foreign
	Director		342-24-3022	1 □ M 2 □XF	89 Yrs	·	Days	louis IV		6 1916		" IL
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					11	Od. Inside City Limits
	Maryl f sho	to	II Ma	rion		Sa	ndova	1				1∭Yes 2∏No
	r 28a	irec	10e. Street and Number	1 1011		10f. Zip (10g. Citizen of W	hat Coun	try?
	th with	Funerai Director	604 N. Clay				628	882			USA	
	r dea	ner	11. Marital Status	Armed For	dent Ever in U.S. 1 ces?	3. Was Decede If Yes, specif	ent of Hispa fy Cuban, N	nic Origin? Nexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race Black	- Americ , White,	
36	rs afte	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Tes If Yes, Give Year or Da	2 ⊠ No etes:	1 🗆 Yes 2	D∏No S	pecify:		Specify:	Wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show that the Madical Examination to ust be multified at	ted	15. Decedent	's Education	16a. De	cedent's Usual	Occupation	1 ,		16b. Kind of Bus	iness/Inc	dustry
215	thin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	ive kind of work e. DO NOT use	e retired)		vorking			
2	ygien ygien rer th	Con		6	Te	eacher/				Unive		у
Maryland	be fill ntal H ad oth	Be	17. Father's Name (First, Middle, I Frederick	Seidel			18.	ESSI	Name <i>(First, Middle,</i> e Wil)	
IZ.	should nd Me mark matic	2	19a. Informant's Name/Relationsh		19b. M	ailing Address	(Street and		Rural Route Numbe		state, Zip	Code)
	nd 2 ; alth ar 27 is r treu		Edward Seidel						Washingto			
ore,	of Hez		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 □Domount (A) S	20b. Place of Di	sposition (Name crematory or oth	e of her place)	De	C. Date 11	20c. Location - C	City or To	wn, State
Ĕ	Pagement ent: h		'4 □Donation 5 □ Other (Sp		Hillcre		•		2005	Centrali	a, I	llinois
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department: If item 27 Is marked other than "natural", or Items 23a or 28a-f show eny injury or other treumatic event, the Mardical Extrating or other treumatic event, the Mardical Extrating results indifficit at 900.		21. Signature of Funeral Service	icen by		22. Name and 3111			Stalling Road, Pasa			ome, P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death. Do not sch line.	enter the mode	of dying, s	uch as card	liac or respiratory a	rrest,		Approximate Interval Between
	Physician	0.1	Immediate Cause (Final disease or condition	a	Congest	ve L	earl	fa	ilure			Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a construence of):	0	0	1 .0				m
		er	Sequentially list conditions, if any, Lauring to innectate	b. Oue to (c	or as a consequence of):	ren	u j	مست	~~			,
	cuted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G	HI	\mathcal{N}	·					Y 1.
oʻ	cate be executed physician and the burial-transit		resulting in death) Last	Due to (d	or as a consequence of):							
8760,	physic physic the b	Physician/Medical		d								
9	death certific e attending p d for use as	/Me	IF FEMALE:	23c. If yes, outo	come of pregnancy					23d. Date	of delive	any.
Вох	d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live bi 4□Pregna	rth 2 ☐ Fetal death ant at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe				Moni		Day Year
Ö.	that the death ed by the atte detached for	hysi	9 Unknown	9□ Unkno	wn							
ds, P	S US	by	Part II. Other significant condition		_	e underlying ca	use given ir	n Part I.		obacco use contril Yes 2□No 3	bute to th	000
of Vital Record	w require been sig should b	Completed		GI B	(and of				24a. Was	an 24b. W	ere auto	psy findings available
Re	The law rate has be page 2 sh	omp		Meni.	fih's				- autoj perfo 1 ☐ Yes	rmed? 🖊 de	eath?	psy findings available incletion of cause of 2 No
ital		BeC	25. Was case referred to medical				26	6. Place of I	Death (Check only o			20140
) f <	d is	To	examiner? 1 Tes 2 Tho		npatient 2 ER/Outpa			4 Norsin	g Home 5 Resi	dence 6 Other	r (Specify	1)
	ing Pl	on:	27. Manner of Death 1		of Injury h, Day Year) 28b. Tim Inju		Bc. Injury at Work?	2 C N -	28d. Describe	now infury occurre	d	
Division	Attending r death. ector: After by the fune	icati	2 Accident investig	ot be	of Indury - At home farm	M street factory		2 🗌 No	28f Location /	Street and Numbe	r or Rura	l Route Number
Di∨	- = E	Certification:	4 ☐ Homicide determ	ned buildin	of Injury - At home, farm, ig, etc. (Specify)	street, lactory,	Office		City or To		or riara	rriode rumber,
	To the Hospitel of within 24 hours all To the Funerel D completely filled in	edical C		g Physicien: To the Examiner: On the ba and mann	best of my knowledge, d sis of examination and/o er stated.	eath occurred a r investigation,	it the time, o	date and pla on, death o	ace, and due to the courred at the time,	cause(s) and man date and place, as	ner as st	ated. the cause(s)
	To the Hos within 24 hr To the Fun completely	Me	29b Signature and title of certifier	. ^	Hende	₽ 29c.	License nu	ımber	2	29d. Date signed	(Month,	Day, Year)
}	-2/	2	Bull	Two.	My		266	74	2	Decemb	er S	, 2005
1	0		30. Name and address of person	the completed cause	best of my knowledge, desis of examination and/or stated. How the stated of the state	pe, Print)	k Rò) . Cq	terysile	· , ~	5 2	.1228
Ì	Sta Regist		31. Date filed (Month, Day, Year) DEC 1 3	2005 R	egistrar's Signature	2346						
	riegist	· U	レレウェ 0		man on the							

			For State Registrar	State	of Marylar		artment of rtificate of			lental Hyg	iệne () E	5 4	015	3
1			1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Year	3. Time of	Death
	Physici /Medic		Nancy L.		oup					Decembe	r 12 2	005	1:45	PM
1	Examin	er	4a. Facility Name (If not institution,		ımber)		4b. City, Town,				4c. County		d - 7	
- 4		*	7881 Elizabeth 5. Social Security Number	KOdd 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	Pasade Ir If Under		8. Date of Birth		e Ar		or Foreign
2	Funeral Director		225-54-8833	1 □ M 2 💢 F		62 Yrs.	Months Day	s Hours	Min.	Oct. 03	1943	Cour	lace (State o	v o o o g
-	P .		Usual Residence of Decedent		10- 0	- T							Od Japida C	in disease
	I within 72 hours after deeth with the Maryland iene. iene. rthan "natural", or Iteme 23a or 28e-f ehow tre Medical Examinat must be notified at	ō	Maryland Anne	Arundel	100. C1	ty, Town or Lo		sadena	a a			,	0d. Inside C 1 🗌 Yes	2 ⊠ No
	the N	Funeral Director	10e. Street and Number				10f. Zip Code			1	Og. Citizen of \	Vhat Cour	ntry?	
	3a or	٥	7881 Elizabeth	Road				2112	2		-	JSA	,	
	deeth	nera	11. Marital Status		edent Ever in U	I.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Or	igin? (Spe	ecify Yes or No-		e - Americ	an Indian,	
9	or Ite	y Fu	1 Never Married 2 Marrie		2 □ N0		1 ☐ Yes 2 ☐XN			1110411, 010.7	Specifi	l lb -		
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced		Dates:	16a Dece	dent's Usual Occ	unation			16b. Kind of B	isiness/lni	duetry	
5	n na	plete	(Specify only highes	grade completed		(Give	kind of work don DO NOT use reti	ne during mos red)	st of worki	ng	TOD, KING OF C	23110337111	303117	
212	d within giene. or then	Completed	Elementary/Secondary (0-12)	Z Z	(1-4or 5+)	Trans	portatio	on Mana	ageme	ent	Federa	1 Gov	/ernme	nt
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, L					100		(First, Middle, M	Aaiden Suman	10)		
yla		ပ္	Robert Lee	Gilmar	1			Mae		Nelson				
Maryland	12 ha 7		Harvey J. Stro		ouse)					<i>Pasaden</i>			Coae)	
	1 an Heal Hem 2		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other p	daga) -		Date	20c. Location -	City or To	wn, State	
e E	00= =		1 Surial 2 Cremation 4 Donation 5 Other (Si				Veteran:		Dec. 200	05 16	Crownsv	ille	, Mary	land
Baltimore,	permit. Pag Department Important: any njury o		21. Signature of Funeral Service	icens	1 al) 2	2. Name and Add		S S	Stalling nd, Pasa				.А.
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dea	th. Do not en						ا کے کاا	Approximation of the state of t	le tween
1	Physician		Immediate Cause (Final disease or condition	A C	AP 0	C	hronic	\sim	001	Factor	2 4		Onset and	
1	/Medical		resulting in death)	a. Due to	(or as a consec	quence of);	- Micolific	_ ~~		, acco				~~
ч	Examiner		Sequentially list conditions,	b	ree to	سيليد	e wil	the o	Nan	spla	nt_		4"4	COM
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence ot);				`			0	
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):								
8760	death certificate be executed the attending physicien and of for use as the burial-transit	cal		L a										
9	ntifical ng phy as th		IC CENAL C.											
Вох	death certifica attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Teta	al death 3	⊒Ectopic pregnar	ncy			1	te of delive		Year
_	t the dea by the al	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□ Unk	nant at time of a	death 5[Other (specify)						,	
P.0.	de de		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	inderlying cause	given in Part	l.	23e. Did tot	acco use conf	nbute to the	ne cause of	death?
Records,	uires sign lid be	d by	Huportensi	S/S						1 □ Ye	s 2 No	3 🗌 Prob	ably 4 🗌	Unknown
Ö	s been s should	Completed	Osterno	Cai						24a. Wasa	n 24b.	Were auto	psy findings	available
Re	The lav	E								autops perform	ned?	prior to co death? I □ Yes	mpletion of a 2∐ No	ause or
Vital		Be C	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only on				
of V	Physicien: this certificant	2	1 ☐ Yes 2 No		Inpatient 2		III 30 DOA		ursing Ho		nce 6 Oth	` '	у)	
		lon:	27. Manner of Death 1 Natural 5 ☐ Pending	9	of Injury nth, Day Year)	28b. Time o Injury	V	juryat łork? ⊡Yes 2.⊡		28d. Describe ho	w injury occur	red		
Division	tten deat stor: the	ficat	2 Accident investig	ot be	e of Injury - At h	nome, farm, st	reet, factory, offic			28f. Location (St	reet and Numb	er or Rura	I Route Nun	nber.
Div	after after Direct	Certification;	4 - Homicide determine	buil	ding, etc. (Spec	ify)	, , , , , , , , , , , , , , , , , , , ,			City or Town				
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier Certifyin (Check only one)	g Physician: To the Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or is	th occurred at the evestigation, in m	time, date ai y opinion, dea	nd place, ath occurr	and due to the cared at the time, d	ause(s) and ma ate and place,	and due to	tated. the cause(s)
	vithin o the omple	Mec	29b. Signature and title of certifier		1		29c. Lice	ense number		, 2	9d. Date signe	d (Month.	Day, Year)	
		/	James a	5Kick	for	2	ml	H44	1904	/	121	13/0	5	
1	0		30, Name and address of pers	who completed car	use of death (Ite	m 23a) (Type	Print)	00		Hwy St.	2.1.	2	a.u A	40
	St	ate	AUREN B. K 31. Date filed (Month, Day, Year)	JCHTE	Registrar's Sign		4068	J. UK	einl	twy of	504 Ut	enplik	NIE /	14)
	Regist		31. Date filed (Month, Day, Year) DEC 1 3 201	15 Sie Con	De St	Good	9							

				Plea	_	-								II Copies		•	gible.	
		•	For State Registrar		;	State o	f Ma	rylan			ent of ate of			Mental Hy	ygierne Reg. No	U	05	40154
			1. Decedent's Nam	ne (First, Midd	le, Last)									2. Date of D Month	eath Da	v	Year	3. Time of Death
	hysicia /Medic		Salvatore											December	r 10.		2005	8:00 AM
E	xamin	er	4a. Facility Name (reet and nui	nber)			4b.			tion of Death		4c	. Cour	ity of Deat	h
F.,			Lorien Nur 5. Social Security		6. Sex		7. Age	(In yrs.)	ast birtho	av) If U	nder 1 Yea		nder 24 Hrs.	8. Date of B	irth		N/A 9. 8 int.	hplace (State or Foreign
	neral ector		216-10-671		1)[]	M 2□F		95	Yrs	Mon	ths Days	s Ho	urs Min.	March 2	lav, Year)	lo	Co	untry) 1 Africa
pu.	2		Usual Residence of	of Decedent				10c Cib	. Town o	r Location	•							10d. Inside City Limits
Maryla	ed at	ō	Mary land	100. County	N/A			100. 01.	Balti									1 ☐ Yes 2 🕱 No
the	Iteme 23a of 28a-1 eno	Director	10e. Street and Nu	umber	N/A				Daici		. Zip Code				10g. Cit	tizen o	f What Co	untry?
th with	ust be	al D	5105 Fran	nkford Av	enue						2	1206			Ur	ni te	d Stat	·es
r dea	Carcill	Funeral	11. Marital Status			2. Was Dece	edent E	ver in U.	S.	13. Was D	ecedent of specify Cu	Hispani Iban, Me	c Origin? (Sp xican, Puerto	ecify Yes or N Rican, etc.)		14. R		rican Indian,
s afte	5 📱	by F.	1 Never Mar 3 Widowed	7.	1	Armed Fo 1 ☐ Yes If Yes, Gir Year or D	/8	0			es 20X No		ecity:			Spec	ihe	
P hour	dical Ex			15. Deceder	nt's Educa	ation	ales.		16a. De	ecedent's	Usual Occu	upation		_	16b. K	ind of	Business/	
hin 7.	Madi	plet	(Spe Elementary/Sec	ondary (0-12)	st grade	College (I-4or 5+	-)	(G lit	ive kind o e. DO NO	of work done OT use retir	e during red)	most of work	ing				,
ed wit	event, the Medical	Completed	12 Year	`S		Years			Д	rchite	ect						tura1	Design
tal ti	0 of	Be	17. Father's Name		Last)									e (First, Middle		Suma	ame)	
should be filed within 72 hours after death with the Maryland Menial Hygiene.	mark	၉	Biagio S		ship (Type	e Print)			19h M	lailing Add	Irass (Stree			na Scol		or Tow	n State 7	Tin Code)
nd 2 s	27 le		Anna Salem		,,	-, ,				-	ankfor			altimore.		212		
es 1 and of Heelth	r othe		20a. Method of Dis			mayal fram	Ctoto	20b. P	lace of Di	sposition	(Name of or other pl			Date				Town, State
Pages ment of 1	ury o		4 Donation	5 Other (S	Specify)					Memor	ial Par	^k	12/13/					e, Maryland
Jepert	Important: If item 27 te marked other then eny injury or other treumatic event, tre Ms once.		21. Signature of	uneral/Service	Licensed	Charles	F.	Miner			e and Add			5305 Ha				21214
uu.	200		23a, Part1, Enter	the disease, o	r/complica	ations that o	aused 1	he death			rd J. F			Baltimo		ldr'y	Idria	21214 Approximate
Dhua	isian		23a. Part1. Enter shock, or he Immediate Cause	(Final	only one	cause on e	0			A	1000000	, ing, 300	\	a a	arrost,			Interval 8 etween Onset and Death
	ician dical		disease or conditi resulting in death)	ion)	a.	Due to		consequ	uence of):	WI	derg		Deas	5				
Exar	niner		Sequentially list or	onditions	b.		CI	won	12) b 57	ruch	M	Puhu	maty	Dos	eas.	,	
2	sit	lner	Sequentially list of if any, leading to in cause. Enter Und Cause (Disease o	mmediate lerlying	ł	Due to	(or as a	consequ	uence of):					-				
xecut	cien and ourial-transit	Examiner	that initiated event resulting in death)	15	c.	Due to	or as a	consequ	uence of):									
8 8	attending physicien for use as the buria				Ld.													
difficat	as th	Medi	IS SSMALE.															
the ce	itendir or use	an/N	IF FEMALE: 23b. Was deceder in the past 12		230	c. If yes, out 1 ☐ Live t				3 □Ectop	oic pregnan	су					ate of deli	very Day Year
) et	the a	Physician/Medical	1 ☐ Yes 2 9 ☐ Unknow	☐ No		4∐Pregr 9□ Unkn		ime of de	eath	5 Othe	r (specify) .						north)	Day 18a7
that th	signed by the signed be detached		Part II. Other sign	ificant conditi	ons contr	ributing to d	eath but	not resu	ulting in th	e underly	ng cause g	given in F	Part I.	23e. Did	tobacco u	use co	ntribute to	the cause of death?
Seunt	5 6	d by	V/e	vigh	era		Vai	Ben	1 m	V) isen	1		1 🗆	Yes 2	□ No	3 🗆 Pr	obably 4 Hunknown
a š	2 should t	plete	DV	rabe	+	25	M	e 11	743					24a. Wa		24b	. Were au	topsy lindings available
The :		Completed			, ,									perf	opsy formed? 2 No		death?	completion of cause of 2 No
cian:	this certificate na director, page	Be (25. Was case rele examiner?	erred to medica	-	anital:							Place of Deat	h (Check only	one)			
Phys	ral dir	- T	1 Yes 2		110	spital: 1 28a. Date	npatien		ER/Outpa 28b. Tim		JOOA		Nursing Ho	me 5 Res				city)
g th	: Atte	tlon	1 Natural	5 🗌 Pendi	ng igation	(Mon	th, Day	Year)	Inju		28c. Inju	ork? ⊒Yes	2 □No	252. 250025		., 000.		
Atter	by th	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deterr	not be nined	28e. Place	of Injui	y - At ho	ome, larm	, street, fa	ctory, office	9		28l. Location	(Street an	nd Nun	nber or Ru	ral Route Number,
ite o	n pel	Cer																
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funerel Director: Affer completely filled in by the funer	edical	29a. Certifier (Check only one)	1 ☑ Certifyi 2 ☐ Medica	ng Physic Examine	cian: To the er: On the b and man	asis of (examinal	wiedge, d tion and/o	eath occu r investiga	rred at the ation, in my	time, da opinion,	te and place, death occur	and due to the red at the time	e cause(s) , date and	and r	manner as a, and due	stated. to the cause(s)
To the	o the	Med	29b. Signature and	d title of certific	er _	And man	iloi stat				29c. Licer	nse num	ber		29d. Da	te sigr	ned (Month	n, Day, Year)
r >1	,		•		11 2	+an	1	Del	IKI	MA	1)	51	148		10.	200	her	12 2005
	6		30. Name and add	dress ol persor	who com	pleted caus	se of de	ath (Item	_	pe, Print)	1 4	. ^	1 3	10	7	11	- V-1	Carolan
		40	31. Date liled (Mo.	nth. Day Year	100	wen	Ly legistre	r's Signa	5 0 7	N	1. M	d.14	onal	10/20	Q	10	11	
, F	Sta Registr		DE	C132	005	Level	Sylvii di	A. S.	A DO	ويصا			J					

State Registrar 31. Date filed (Month, Day, Year)

3 2005



1

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

O.C.M.E

DEC.

4, 2005

			1 - For State Registrar	e of Maryland / Dep Ce	partment of Health a		2005 L	0156
- ag	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dorothy Elizabet	h Sherman		2. Date of Death December	7 ^{ay} , 2005 ^{ar}	3. Time of Death 8:50 рм
* 4	Examin		4a. Facility Name (If not institution, give street ar Oak Crest		4b. City, Town, or Location of Baltimore		4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 215-34-9603 Usual Residence of Decedent	7. Age (In yrs. last birthda) 85 Yrs.	// If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birth (Month, Day, March 2,	rear) Coun	ace (State or Foreign try) Tand
	Maryland -f show first at	tor	10a. State 10b. County Md. Baltimore	10c. City, Town or I Baltim			10	0d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	3a or 28a	al Director	10e. Street and Number 8810 Walther Blvd.		10f. Zip Code 21234	10	g. Citizen of What Coun	try?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Mudical Exam at market indifficular at the conflict of the	by Funeral	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 👿 No s, Give or Dates:	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	n, Puerto Rican, etc.)	14. Race - America Black, White, 6 Specify:	
215-0	ithin 72 ho ne. nen "natur	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colle	eted) (Giv life.	edent's Usual Occupation re kind of work done during mos DO NOT use retired)	t of working	6b. Kind of Business/Ind	
Maryland 21215-0036	should be filed within and Mental Hygiene. s marked other than " umatic event, It a Me	To Be Cor	17. Father's Name (First, Middle, Last) Quincy Lee Morrow	+4 Nurs	18. Mothe	er's Name (First, Middle, Ma rothy Dieden		ire
	1 and 2 sho Health and I tem 27 is mu		19a. Informant's Name/Relationship (Type, Prin Mr. Charles Lee Sherman 20a. Method of Disposition		ling Address (Street and Number 05 York Manor F	Rd. Phoenix,		
Baltimore,	Page nent o ant: If ary or		1 □ Burial 2 🔯 Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundarial Tervinde Licensises	from State Hilltop	ematory or other place) Service Co. 1	12-9-05	Towson, Md.	
Ba	Departition Departition Departition Departition Departition Departition Department of the Department o		23a. Part1. Enter the disease, or complications	that caused the death. Do not e	22. Name and Address of Facili Ruck Towson F 1050 York Rd nter the mode of dying, such as	. Towson, Md.	21204	Approximate
HARTE	Physician /Medical Examiner	2 .5	resulting in death)	e to (or as a consequence of):	an Accident		10	Interval Between Onset and Death
8760,	ate be executed hysicien and he burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of).				
.O. Box 6	it the death certifica by the attending placed for use as t	Physician/Mec	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ry Day Year
0	quires that t n signed by uld be detao	þ	Part II. Other significant conditions contributing Demen 19	g to death but not resulting in the	underlying cause given in Part I	. 23e. Did toba	cco use contribute to th	e cause of death? ably 4 Unknown
of Vital Records,		Completed				24a. Was an autopsy performe	prior to con	osy findings available inpletion of cause of
f Vit	ysician: 1 is certifice director, p	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No Hospital:	1 Inpatient 2 ER/Outpati	Othor	of Death (Check only one) ursing Home 5 Mesiden	ce 6 Other (Specify	")
Division o	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b. Time (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐			
Divi	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	Certifle	4 Homicide determined	Place of Injury - At home, farm, s building, etc. (Specify)		City ar Town,	,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	one) 2 Medical Examiner: On	the best of my knowledge, deathe basis of examination and/or manner stated.	investigation, in my opinion, dea	th occurred at the time, dat	e and place, and due to	ated. the cause(s)
	To t within	×	29b. Signature and title of pertifier	cause of beath (liegn 23a) (Type	29c. License number	296	d. Date signed (Month, I	
	10		30. Rape and address of rerson who complete	cause of death (New 23a) (Type	ville, MD	21234		
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 3 2005	32. Registrar's Signature	Rock B			
DH	MH 17 Rev 1/2	001	———— DEC 1 3 2005	ORIGI	NAL			

			1 - State of Registrar	Maryland / Departm Certific	ent of Health and Nate of Death	ental Hygier	1000 4010/
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CHARLOTTE BYE	SMITH		2. Date of Death Month DECEMBER	3. Time of Death 9. 2025 4:45 A
	Examir		4a. Facility Name (If not institution, give street and num Saint Joseph Medica	,	City, Town, or Location of Death		4c. County of Death Baltimore
**	Funeral Director		5. Social Security Number 3 6. Sex 1 M 2 LVF.	7. Age (In yrs. last birthday) If Ur Mont	nder 1 Year If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Maryland I show	ō	Usual Residence of Decedent 10a. State 10b. County RALTTMOR	E 10c. City, Town or Location	DM.		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a-	Funeral Director	10e. Street and Number 2300 DULANEY VAI	1 ////0/4/	Zip Code 2 1093	10g. (Citizen of What Country?
020	urs after deati af', or iteme 2 Examiner mu	by	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year or Da	2 ∰ No 1 ☐ Ye	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto es 2 WNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
0-61212	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Sa or 28a-f show other thaumatic svent, the Maxical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-1)	life. DO NO	Usual Occupation f work done during most of work IT use retired) MEMAKER	ing 16b.	Kind of Business/Industry AT HOME
yland	should be filed nd Mental Hyg i marked othe umatic svent,	To Be C	17. Father's Name (First, Middle, Last) CLARENCE B	(E	18. Mother's Nam MARTH	e (First, Middle, Maid A MARY	en sumame) TANE SCHORR
ž Ú	Pages 1 and 2 sh nent of Health and int: if item 27 is m iry or other traum		19a. Informant's Name/Relationship (Type, Print) MR. STEPHAN G. SM 20a. Method of Disposition 1 Burial 2 Mcremation 3 Removal from S	20b. Place of Disposition	ress (Street and Number or Rur B Ma.L.COL (Name of or other place)	m CIRU	Location - City or Town, State
_	permit. Pages 1 a Department of Hez important: If item any injury or othe once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22. Name CYCM	e and Address of Facility ba	ceful Alk	mative funeral and mo 21093
	Cale be executed by Second of the price of t	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	INARY EDEMA or as a consequence of):	mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
O. DOX O	w requires mat the death certific been signed by the attending p should be detached for use as	Physician/Med	in the past 12 months?	nt at time of death 5 Other	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Clus, r.	equires that on signed by ould be deta	þ	Part II. Other significant conditions contributing to de	ath but not resulting in the underlying	ng cause given in Part I.		o use contribute to the cause of death?
מו שמכי	i: Ine taw re icate has be r, page 2 sho	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 22 No
	To the hospital of stending Prysician: The law requires that the death certificate be executed within 24 bareat air steads after death. To the Funeral Director After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	atlon: To Be	27. Manner of Death 1 X Natural 5 Pending (Month 2 Accident investigation		DOA Other: 4 Nursing Ho	n (Check only one) me 5 Residence 28d. Describe how in	6 □ Other (Specify) jury occurred
	ina or And ins after de rai Directo	Certification:	4 Homicide buildin	of Injury - At home, farm, street, fac g, etc. <i>(Specify)</i>		City or Town, Sta	
	in 24 hours file For the file f	Medical	29a. Certifier (Check only one) Certifying Physician: To the ba and mann	pest of my knowledge, death occur sis of examination and/or investigat er stated.	red at the time, date and place, tion, in my opinion, death occurr	and due to the cause ed at the time, date a	s) and manner as stated, nd place, and due to the cause(s)
	with Con	2	29b. Signature and title of certifier P	Ala mo	29c. License number D 41412l		Date signed (Month, Day, Year)
	Ψ		30. Name and address of person who completed cause		DOTHE TOLICO	4 MARYLAN	MD 212014
	Sta Registr		31. Baie filed Month, Day, Year, MEHTA 32. Re DEC 1 3 2005	gistiar's Signature		7 - 1*88-11 T h 1-11	The state of the s

			1 - For State Registrar	State of Maryland / Depa Cea	artment of Health and Natificate of Death	Mental Hygier	000 40100
			Decedent's Name (First, Middle, Last)		***************************************	2. Date of Death Month	3. Time of Death
	Physicia /Medic		Helen Sur Ki	ewicz		Desen 60	10 3000 C 07 1 M
Q	Examin		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or Location of Death	4	c. County of Death
			Benesis Brightwood	Nussing Facelity	LutherVille		Baltmore
	Funeral Director		47-16-7212	7. Age in yrs. last binthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City. Town or Lo	ocation		10d. Inside City Limits
	Aaryl sho	ŏ	MD Bolles	30 /4:	70RE		1 Tes 2 No
	1he N 28a-	rect	MD Ba/hmox	ce Juin	10f. Zip Code	10g. (Citizen of What Country?
	with 3a or	٥	415 Cedarcron	DL DN	21212		USA
	Jeath Trans 2;	era		Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
(0	r Iter	Funeral Director	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
ဇ္ဇ	ral', o	by	3 ₩Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: WKIFE
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Madical Examiner must be notilled at	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b.	Kind of Business/Industry
7	ithin	ndu	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		OWN Home
N	filed with Hyglene other tha ent, the		17. Father's Name (First, Middle, Last)		to memaker	e (First, Middle, Maid	
and and	buld be fi Mental H arked ot atlc ever	Be		1-12			
Ĕ	should and Men marke umatic	ဥ	Harry Harry 19a. Informant's Name Relationship (Type		ng Address (Street and Number or Rui		
Ma	d 2 sho th and 7 Is ma traum			VICE -SON 615	1 1 1		nne M \ 2/2/2
Ġ,	1 and Health tem 27		20a. Method of Disposition	20b. Place of Dispo		Date 20c.	Location - City or Town, State
<u>0</u>	Pages nent of I ant: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	matory or other place) WIF (EMERIL) 12/1.	11-	De Himmen Mi
Baltimore, Maryland		1	21. Signature of Funeral Service Licensee	U11 EEN 1110	UNT (PRE RRU) 12/1, 2. Name and Address of Facility	2/05	saltimore MD
Ba	permit. Departr Imports any inje		1 () State of the	mo1455	2 Name and Address of Facility Bradiest ASK for 2134 W, 110W	STUNERA PI	1 Home, F.H.
т.	_		23a. Part1. Enter the disease, or complica	tions that caused the death. Do not en			Approximate Interval Between
	Pnysician		shock, or heart failure. List only one Immediate Cause (Final	and the same of th	Died of	Believe Co	 Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	mic Obstructure F		Place
	Examiner		Sequentially list conditions				
5	D =	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	acute ind trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last				
90,	oe exected a	E	100diting in dodain, Edot	Due to (or as a consequence of):			
8760,	icate be executed physicien and s the burial-transit	dical	d				
9 X	death certificate be executed e attending physicien and ad for use as the burial-transit	Physician/Me	IF FEMALE: 23c. Was decedent pregnant 23c	. If yes, outcome of pregnancy			23d. Date of delivery
Вох	leath atter	clar	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O.	the cachec	hysi	9 Unknown	9 Unknown			
	res that the de signed by the a be detached f	by P	Part II. Other significant conditions contri	buting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	use contribute to the cause of death?
ğ	v require been sig should b	edt		***		1 🗆 Yes	2 No 3 Probably 4 Denknown
Records	law requires as been sign 2 should be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
m	0 L 0	m _o				performed	death?
Vital	i clan : Th certificate ector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Dear	th (Check only one)	
<u></u>	Physiclan: this certific ral director,	2	1 ☐ Yes 2 ☐ No	spital: 1 Inpatient 2 ER/Outpatien		ome 5 Residence	6 ☐Other (Specify)
ם	ng P	ü.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred
sio	Attending r death. sctor: After	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	201 1 1 (01	
=	lor At after o Direct	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town, Sta	and Number or Rural Route Number, ate)
	Hospital or 14 hours afte Funeral Dir tely filled in		29a. Certifier Certifying Physic	ian: To the best of my knowledge, deat	th occurred at the time, date and place	and due to the cause	(s) and manner as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical		r: On the basis of examination and/or in and manner stated.			
	To th within Fo th	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
			1 Andread		D59423	Dar	mber 12 2005
	10		30. Name and address of person who com	pleted cause of death (Item 23a) (Type,	Print)	700	more MD 2/239
_	1		Which Thubery Gor		tal Bot Building F	#303 Daly	more MU2/239
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature			
	Regist	ar	DEC 1 3 200	Barrens It All	SALL		

		-	For Stete Registra Amend Item #	State of Man				6	ne 05	40159
			Decedent's Name (First, Middle, Last))U_12/2U	707 Ju		2. Date of Death Month	Day Year	3. Time of Death
	Physicia		MARTHA BELLE	SCHROCK				12-11-2		9:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1	4c. County of Dea	th
			934 Reece Road			Severn			Anne Aru	
	Funeral		Social Security Number 6. Se	TAL OVERLE	n yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth 1 (Month, Dey, 7 11-10-20	9. Bir	thplace (State or Foreign ountry)
	Director		1/5-20-1299	8 - AAS ME	30 Yrs.			11-10-20	05 PA	
	pue *		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryti F sho	5	MD Anne Aru	nde1	Severn					1 ☐ Yes 2X No
	the h	Director	10e. Street and Number	nder	Bevern	10f. Zip Code		100	g. Citizen of What C	ountry?
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Frantier must be notified at	٥	934 Reece Road			21144			U.S.A.	
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of h	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Whi	
ဟ	or Iter	고	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2200No		1 ☐ Yes 2 ②XNo		o rican, etc.)	Specify: Wh	
21215-0036	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10 163 202110	apouly.			
5-0	72 hc natur	etec	15. Decedent's Ed (Specify only highest grad	ication de completed)	(Give	dent's Usual Occup kind of work done	during most of wor	king 16	3b. Kind of Business	/Industry
2	ithin ne.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	LPN	DO NOT use retire	a)		Healthc	are
2	tygier therti		12 17. Father's Name (First, Middle, Last)		LFN		18. Mother's Nan	ne (First, Middle, Ma		are
and	be find H H H H H H H H H H H H H H H H H H H	Be						eth Lawso		
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "Iraumatic event, the Me.	ဥ	Samuel McCurdy 19a. Informant's Name/Relationship (7)	vne Print)	19b. Maili	ng Address (Street		ral Route Number,		Zip Code)
Mai	d2 sh th and 7 Is r traur		Mr. C. Vernon Sch					rn, MD 21		
e,	1 and Healt em 2		20a. Method of Disposition		20b. Place of Dispo	osition (Name of			Oc. Location - City o	Town, State
٥	ages nt of t: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐			matory or other pla	I	15-2005	Crowneyi1	1e. MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic as <u>once</u> .		 4 □ Donation 5 □ Other (Specify 21 Signature of Funeral Service Licen 		2			ngleton F		
Ba	Departimbol	/	100 X/41- 6	mov	718			Glen Bur		
			23a. Part1. Enter the disease, or comp	dications that caused th	e death. Do not en					Approximate Interval Between
			shock, or heart lailure. List only immediate Cause (Final			000	- Live		ichin	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		onsequence of):	10 in	-los	- restr	1. 1	-
	Examiner			stroi	Ke.	o, into	aice -	>700(10	nov	'0]
		آة	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	death certificate be executed e attending physician and of for use as the burial-transit	Examine	that initiated events	. H		voin.				
oʻ	e exe ian au urial-t	Ä	resulting in death) Last	Due to (or as a	consequence of):					
8760,	ate b hysic the bi	llcal	•	d						
68 ×	e as	Physician/Med	IF FEMALE:	22e If use sutcome of	prognancy				22d Date ol d	olivan
Box	ath ce ttend or usi	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	☐Fetal death 3	Ectopic pregnand	;y		23d. Date of de Month	Day Year
	e deg	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne oi death 5	Other (specify) _				
P.0	res that the de signed by the a be detached f	F.	Part II. Other significent conditions of	ontributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23a. Did toba	acco use contribute	to the cause of death?
ds,	requires t een signe nould be	1 by						1 ☐ Yes	s 2,511√10 3F	Probably 4 DUnknown
Records,	w require been sign	Completed						24a. Was an	24b. Were a	autopsy findings available
3ec	12 G	I du						autopsy perform	ed? prior to death?	completion of cause of
a	i icia n: The l certificate ha rector, page						OC Place of Do	1 Yes 2 ath (Check only one		es 2 No
Vit.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA 0	har	dome 5 Hesider		necify)
of Vital		5	1 Yes 2 No 27. Manger of Death	28a. Date of Injury	28b. Time			28d. Describe how		outy
o	ding I h. After funer	tou	1 Natural 5 ☐ Pending investigation	(Month, Day	Yea <i>r)</i> Injury		ork?]Yes 2□No			
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not b	28e. Place of Injur	y - At home, farm, s	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or I	Rural Route Number,
Θ	after after Dire	Certification;	4 Homicide	building, etc.	(Specity)			City of Town,		
	spita nours neral	alC	29a. Certifier 1 Certifying Pl	ysician: To the best of niner: On the basis of e	my knowledge, dea	th occurred at the	time, date and place	e, and due to the car	use(s) and manner:	as stated.
	n 24 J n 24 J ne Fu	ledical	(Check only 2 Medical Example)	and manner state	ed.					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	×	29b. Signature and title of certifier				ise number	29	ld. Date signed (Moi	
			long	melita 1	LID	D3	9030		12/12/	05
	6		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print)	111	CILLO		
_	τ		1132 Annap	olis Kd	O de	utan	(01)	21/10		
		ate	31. Date filed (Month, Dey, Year)	completed cause of dec	's Signature	Cartes				
	Regist	rar	LIEU I	3 ZUUJ	1500 50	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 0.05Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SHELLEY JEAN LOUISE December 2005 6:05A 11. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 241-44-3977 80 February 16,1925 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be rediffed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road 21286 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XX Wever Married 2 Married Baltimore, Maryland 21215-0036 1 TesX XX No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Grafton Shelley Elba Hampshere 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) POA/PR Elizabeth Barclay 11630 Glen Arm Road Glen Arm Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXX rial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem Gar dens 12/13/05 * 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy 1 ☐ Yes 2 **2** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 100 2 1 🔲 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death annielius 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. 12, 2005 Year **Physician** Erma Gladys Storms 12:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Cherrywood Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 6, 1911 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 217-12-0140 94 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show ury or other treumatic event, the Medical Examines must be notified at Md. Baltimore Owings Mills 1 ☐ Yes 2 🕅 No Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2721 Baublitz Rd. 21117 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Book kesping Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cleveland F. Bull Goldie Kelbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2721 Baublitz Rd., Owings Mills, Md. 21117 Betty S. Beck - Daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ABurial 2 Cremation 3 Removal from State *4 □ Donation, 5 □ Other (Specify) Pleasant Grove Cem. Dec. 14, 2005 Reisterstown, Md. 21. Signature Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or horard failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Athara is larged to the death. Approximate Interval Between Onset and Death Atharoselarate Coronen Varial Direce **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) physician ar Physiclan/Medlcal as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Jas autopsy performed? After this certificate his funeral director, page 1 Yes 2 ₩o Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 ₽No Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Avatural 5 Pending n 24 hours after death.

Be Funerel Director: Afterely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032882 Roll d. Mr. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 117 Brenon, 2005 32. Restrar's Signature State Registrar

JC 05-08248 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Benjamin Terry State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** December 06, Benjamin Terry, Jr. 2005 17:37 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner John's Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 25, 1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**XX**MM 2□ F Months Days Hours Yrs. Director 406-14-0397 83 Kentucky Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo by Funeral Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 1 Brett Court, Apt. 220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXYes 2□No 1940-If Yes, Give filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No If Yes, Give Year or Dates: Specify Specify: 3XXVidowed 4 ☐ Divorced White 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Food Pages 1 and 2 should be filed vitner of Health and Mental Hygie tant: If item 27 is marked other i jury or other traumatic event, it. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Harrison Terry Nora Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12152 Buttonwood Lane, Baltimore, Maryland 21220 Charles Terry, Sr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. Druid Ridge Cemetery | Dec. 9, 2005 Haltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ski Funeral Home, P.A. 21 Sentitura of Funeral Sensor Ligaris 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple **Fryuries** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760. Physician/Medical attending physi IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ď Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of de th?

Yes 2□ No 24a. Was an certificate has birector, page 2 s performed's 10 Yes 2□No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) Scene ty⊡ Yes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred pedestrian 27. Manner of Death 28b. Time of Injury Certification: struck by motor vehicle is after de. 1 Natural 5 Pending 2 Accident 3 Suicide 1 ☐ Yes 2 No investigation 4101 PM 2/05 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Old Eastern Alenne 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Street Baitimore Co. within 24 hours a
To the Funerel C mo. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

ů,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
DEC 1 3 2005

29b. Signature and title of certifier

tameia E. Southall. mD 32. Registrar's Signature

Duthay, MS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

December 07, 2005

29c. License number

O.C.M.E.

ORIGINAL

			1 - For State Registrar		Marylan	d / Depa	artmer <i>rtifica</i>	nt of H	lealth a	and M		Reg. No	- 40	Ļ	016	53
	Physici	an	Decedent's Name (First, Middle, Last	t)							Date of De Month	ath Day	y Y	'ear	3. Time o	f Death
	/Medic	_	Catherine			•		npson			Decembe				210	М
	Examin	er	4a. Facility Name (If not institution, give						Location of			4c.	. County of			
	M. M.	250	Calvert Memoria 5. Social Security Number 6. Secur		7. Age (In yrs.	last hirthday		I TICE	Frede		8. Date of Bir	th		Calv	ert ace (State)	or Foreign
Н	Funeral Director			_M 2∭ F	75	Yrs.	Months		Hours	Min.	June 15	y, Year)		Count Mary	ry)	or roreign
			Usual Residence of Decedent								odiic 13	J . 1 J.	30 1	ridi j	Tand	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo								10	d. Inside C	
	e Ma	cto	Maryland Anne Ar	undel		Loth										2 No
	h with th	al Director	10e. Street and Number 202 B Court				1	p Code 20711					U.S.A		ry?	
96	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ahow amy pingry or other treumatic event. The Medical Examinal must be notified at ance.	y Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Dece Armed For 1 Tyes If Yes, Give	ces? 2∭No		Was Dece If Yes, spo	cify Cuba	ispanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	White, e		
Ö	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Da	ites:	16a, Dece	dent's Hs	ial Occup	ation			16b K	ind of Busin			
Ω	in 72 in a	siet	(Specify only highest gra	de completed)		(Give	kind of w	ork done o	durina mos	t of worki	ng	100.10	110 01 0031	11033/11/01	25try	
212	r tha	E o	Elementary/Secondary (0-12) 12th	College (1-	-40r 5+)	Home	make						Home	е		
Maryland 21215-0036	d be filed antal Hyg ced othe c event,	To Be Completed	17. Father's Name (First, Middle, Last) Joseph Ollie Wa	alker					18. Mothe Mar		(First, Middle,	Maiden ing	Surname)			
Mary	2 shours and Miles man	-	19a. Informant's Name/Relationship (18 Kathleen Ann Thor		ghter)		_				l Route Numbe			ate, Zip (Code)	
e,	1 and Health em 27 ther t		20a. Method of Disposition	npson	20b. F	Place of Dispo	osition (Na	me of			laryland		711 ocation - Ci	ty or Toy	vn. State	
٥	nt of 1		1 Burial 2 Cremation 3		State _ C	semetery, cre Surrec	matory or	other plac		ec.			inton	•		d
altimore,	it. Pi		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service/Little		I.C					200	Funera			·	-	···
Ba	Departiment impo		Marin J. Had	1-ma	857						Ferry					0735
·	Physician /Medical		23a. Part 1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Vama	used the deat ach line. DWY W or as a donsed	n Res					or respiratory a		ere		Approxima Interval Be Onset and	tween
4	Examiner	Jan 1	Sequentially list conditions.	Seph	ca	Alin	lis	184	fapl	ligh	ococcu	w				
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Acu	HE R	ena	2 7	ail	ure	_						
8760,	ficate be executed physician and is the burial-transit	icai Ex	leading in death, cast	a Dia	lefe	uence of):	le	elis	les							
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2秒 No 9 ☐ Unknown		nth 2 ∏ Feta antat time of d	ildeath 3[⊒Ectopic p ☐ Other (s		,				23d. Date of Month		,	Year
ds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions o	ontributing to de	ath but not res	ulting in the u	inderlying	cause give	en in Part I.		23e. Did t		use contribu		ecause of	
Records,	e law req has beer je 2 shou	Completed									24a. Was		pric	ore autopor for to com	sy findings	available cause of
<u>a</u>	ilcien: The la certificate has rector, page 2										1 ☐ Yes	2 No		Yes 2	2□ No	
ξ	certif	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		IED/O		OA Oth	or		(Check only o		• ====			
ō	Phys r this ral dii	To To	1 Yes 2 No 27. Manner of Death		npatient 2 of Injury on, Day Year)	ER/Outpatie		28c. Injur	4 🗆 Nu		ne 5 Residence R					
0	ding F th: : After funera	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	1	h, Day Year)	Injury	м	Worl	k? Yes 2 □	No						
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not by 4 Homicide determined	289. Place	of Injury - At h	ome, farm, st	reet, facto	ry, office			28f Location (: City or To			or Rural	Route Nun	mber.
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 M Certifying Ph (Check only 2 Medical Examone)		sis of examina											s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1			1	9c. Licens				29d. Da	te signed (Month, D	ey, Year)	
	1		Julin Bu	Ju 1	np			100	604:	75		12	17/1	05		
1	8		30. Name and address of person who		e of death (Iter	m 23a) (Type	Print)						4			
_	V'		TEREZIA BUSH	1	(00		TAR	KD.	PRI	NIE	FRET	DER	rcle	Mi	2	0678
3	Sta Regist		31. Date filed (Month, Day, Year)	005	egistrar's Signa	13. P.	ASAGL	B '								

			1 - For State Registrar	State of	Marylaı			nt of He te of E		l Mental Hy	giene Reg. No.	05	401	64
			Decedent's Name (First, Middle, Last)						2. Date of De	ath			ne of Death
	Physici /Medi		Clarence H. T.	rovinge	er, J	r.				Decemb	er 1	0,200		3:15₽ ^M
	Examir		4a. Facility Name (If not institution, give 2500 W.Belveder			1010			Location of De	ath	4c. C	ounty of De	ath	
	Funeral		5. Social Security Number 6. Se			. last birthday)		1tim	If Under 24 H	rs. 8. Date of Bir	th	9 Bi	irtholace (St	ete or Foreign
Ш	Director			XM 2□F	65		Months	Days	Hours M	in. (Month, Da June 2:	y, Year)	40 Pe	ountry)	ate or Foreign 1 van i a
	D .		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	100 0	in Tarana								
	laryla ehov	ō	MD		106. C	ity, Town or Lo Ba1t								le City Limits Yes 2 \(\) No
	28a-i	ect	10e. Street and Number			Dalu		c Code			10a Citize	en of What C		
	3a or		2500 W. Belvede	re Ave.	Apt	.1018	701. 21		215		rog. Onizi	U.S.	,	
	should be filed within 72 hours after death with the Maryland of Mental Hygiane. marked other than "natural", or items 23e or 28e-f show imalic event, it a Medical Examination mante event.	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U		Was Dece			(Specify Yes or No erto Rican, etc.)	- 14	Race - Am	erican India	n,
36	or it	Y.F.	1 Never Married 2 Married	1 ∐ Yes X2 If Yes, Give	∑ No		ii 193, spe 1		Specify:	ento mican, etc.)		Black, Wh Specify:		_
21215-0036	hours tural	ed by	3 ☐ Widowed X X Divorced	Year or Date	es: 								White	 5
5	n "na	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		16a. Dece	kind of we	ai Occupa ork done du ise retired)	iring most of w	rorking	16b. Kind	d of Busines:	s/Industry	
212	d with	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)	Tri	uck	Driv	er		\mathbf{T}	rucki	ng	
9	be file ital Hy od othe event,	ВеС	17. Father's Name (First, Middle, Last)						18. Mother's N	ame (First, Middle.	Maiden S	u <i>m</i> ame)		
<u>yaa</u>	Ment Ment arked	2	Clarence H. Tro	ovinger	, Sr					en Marie				
Maryland	12 sh h and r is m raum	1	19a. Informant's Name/Relationship (T)		-7- t					Rural Route Numbe				
	1 and Healti am 2 ther t	- 1	Teresa Shumakei 20a. Method of Disposition	. / Daug		IIIZZ Place of Dispo	_		ook Dr	.; Glen		1e, M		
nor	eges int of t: If it y or o	1	XXBurial 2 Cremation 3 F		ate H	Cemetery, cret	natory or o	other place)					
Baltimore,	permit. Peges 1 and 2 should by Departiment of Health and Menta Important: If item 27 is marked eny injury or other traumatic as <u>once.</u>	i	4 □ Donation 5 □ Other (Specify) 21. Signature of furleral Service Licens		Me	emoria				2/13/05 ckhardt		ite Ma		
ä	Depa Impo eny i		1 The had	mus		1	1605	Reis	terst	own Rd.	Owin	gs Mi	11s,N	1D2111
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that cau	sed the dea	th. Do not ent	er the mod	de of dying	such as cardi	ac or respiratory ar	rest,		Approxi	mate Between
	Physician	ñ	Immediate Cause (Final disease or condition	Hear	rt f	Failur	re							ind Death
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):	1							
		e.	Sequentially list conditions, if any, leading to immediate	Mor	bid as a collect	Obes	- + y		-			-		
	uted 1 Insit	Examine	Cause (Disease or injury	220 10 (01	43 4 0011380	quence on.	,							
o .	exection and and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or	as a consec	quence of):								
8760	icate be executed physicien and the burial-transit	dlcal		d				<u></u>						
T)		Med	IF FEMALE:											
ROX	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcor 1 ☐ Live birth	n 2 ☐ Feta	aldeath 3□	Ectopic p				23	d. Date of de Month	livery Day	Year
o.	0 0 0	Physician/Me	1 Yes 2 No	4∐Pregnan 9∐Unknowi		death 5∟	Other (sp	oecify)					Duy	i oui
J.	£ 2 €	by Ph	Part II. Other significant conditions cor	ntributing to deat	h but not res	sulting in the ur	nderlying	ause given	in Part I.	23e. Did to	bacco use	contribute t	o the cause	of death?
Records,	w requires been sign should be						_			1 🗆 Y	es 2	No 3 □ P	robably 4	□Unknown
ပ္တ	awre	Completed								24a. Was a	an	24b. Were a	utopsy findin	igs available
	The I	mo			,					autop perfor	SY	death?	completion of	of cause of
Vital	eician: The law certificate has b irector, page 2 s	Bec	25. Was case referred to medical examiner?						26. Place of D	eath Check only or		1 1 103	2	
ō	> º 0	၉	1 ☐ Yes 2 ☑ No	lospital:		ER/Outpatien			4 Indising	Home 5 Resid			ecify)	
Ĕ	After Une	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		28c. Injury a Work?		28d. Describe h	ow injury o	occurred		
DIVISION	N or Attending after death. I Director: After d in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, stre	M eet factor		s 2 No	28f. Location (S	treet and I	Vumber or 8	ural Pouto A	humbor
_	al or / a after i Dire d in b	erti	4 Homicide determined	building,	etc. (Specil	fy)	001, 140101	, ombo		City or Tow	n, State)	Valification of th	urai noute n	umber,
	e Hospital or Atten 24 hours after deat e Funeral Director: letely filled in by the	edical C	29a. Certifier (Check only 2 Medical Exemi	sician: To the be	st of my kno	owledge, death	occurred	at the time	, date and place	e, and due to the o	ause(s) ar	nd manner as	s stated.	
	To the H within 24 To the F complete	Medi	one)	and manner	stated.	ation and/or inv								
	To the within To the comple	~	29b. Signature and title of certifier	leva	0.2-			License r	1915		29d. Date s	2 /2	th, Day, Yea	·)
,	~		20 Name and address of the same	malated	44	- 00-1 7				/	, /	-/2	J05	
	8		30. Name and address of person who co Daniel Alexa		of death (Iten	п 23а) (Туре, I	Star	noha	1100 C	irde Pi	Koc	villa	MA	217=0
	Sta	te	31. Date filed (Month, Day, Year)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	trar's Signa	ature	- 1 OI	·OHE	ye c	11000 11	1567	ALLIC	, • ()	-, -, -,
	Registr	ar	DEC 1 9 208	5		H. An	الكالمات	1						

			For State Registrar		State of Ma	aryland	-	artment of H rtificate of L			_	GIETAE Reg. No	UUU		+016	55
	Dhysisi	0.0	1. Decedent's Name				-				2. Date of Dea	ath		ear	3. Time o	f Death
	Physicia /Medic	al		elyn 	ive street and number)	enzel	•	4b. City, Town, or	Logation		Decembe	_	0, 20		7:40	PM
	Examin	er			rsing Home			Laurel		OI Death					eorge!s	2
I	Funeral Director		5. Social Security N 215-38-68	lumber 6. 356		e (In yrs. la 86	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birt (Month, Da June 7	h y, Year)	9.		place (State ontry)	
	tand		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	Town or Lo	ocation							10d. Inside C	ity Limits
	Mary	tor	MD	Prince	George's	I	Laurel								1 🗌 Yes	2 🔯 No
	or 28	Direc	10e. Street and Nu					10f. Zip Code				10g. Cit	tizen of Wha	t Cou	ntry?	
	eath w	Funeral Director	16208 Doi	set Roa	12. Was Decedent	Ever in U.S	3. 13.	2070 Was Decedent of H		rigin? (Spec	cify Yes or No	US	14. Race -	Ameri	can Indian.	
220	i and 2 should be filed within 72 hours after death with the Maryland Fleatin and Mental Hygiene. I fleat 27 is marked other than "natural; or items 23a or 28a-f show item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified.	by		ied 2 Married	Armed Forces? 1 Yes 241			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2XXNo	n, Mexica Specify		Rican, etc.)		Black, \ Specify:	White,		
ה ה	72 ho natura	eted	(Spec	15. Decedent's	Education rade completed)		(Give	dent's Usual Occupa	during mo:	st of workin	g	16b. K	(ind of Busin	ess/in	dustry	
7	within ane. than "	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	i+)	lite.	DO NOT use retirea	1)			IIC	Gove:	rnm	ont	
2	Hygie other ent,	a)	17. Father's Name				sec	retary	18. Moth	er's Name	(First, Middle,			L 11111	enc	
	should be ind Mental marked umatic ev	To B	Ralph	Bernard	Ramey				Oli	ve Lo	ve Rin	ehar	ct			
_	2 sho and I Is ma		19a. Informant's N					ng Address (Street a				_			code)	
13	of Health of Health litem 27		Judith W.		Daughter	20b. Pl	ace of Dispo	Sandpiper esition (Name of	1		napolis		ID 214 ocation - Cit		own, State	
2	Pages ent of nt: If it			☐ Cremation 3 5 ☐ Other (Spec	☐Removal from State	1	-	matory`or other plac Cemetery	1	12/15	/2005	Lau	rel,	MD		
	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Fu	neral Service Lic	ensee		22	2. Name and Addres	ss of Facil	ity Dona	aldson	Fun	eral 1	Hom		A.
	0.0 5 € 0		23a Parti Enter t		ralder MO			313 Talbo					MD 2	070	Approxima	te
	No.		shock, or hea Immediate Cause	art failure. List on (Final	y one cause on each li	ne.	's Di		g, 50011 ac	ourdias of	Toopiiatory ai	1031,			Interval Ber Onset and over 1	tween Death
	Physician /Medical		disease or condition resulting in death)		a Due to (or as			sease						-	over 1	L year
	Examiner	Ĺ	Sequentially list co	onditions,	b. =											
	nsit	Examiner	if any, leading to in cause. Enter Under that initiated events	nmediate erlying injury	Due to (or as	a consequ	ence or):									
ב ב	execu an and rial-tra		resulting in death)	s Last	Due to (or as	a consequ	ence of):					_				
0,00	lificate be executed g physician and as the burial-transit	edicai		•	d									-		. =
O. DOX O	attendin for use	hysician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[∃Ectopic pregnancy ∃ Other (specify)					23d. Date o Month	f deliv	,	Year
ds, r.	w requires that the de been signed by the should be detached	by P	Part II. Other signi	ficant conditions	contributing to death b	ut not resu	lting in the u	nderlying cause give	en in Part	l.		obacco /es 2			the cause of d	
Records	The law req cate has beer page 2 shou	ompieted										rmed?	prio dea	r to co th?	opsy findings ompletion of c	available cause of
		O	25. Was case refe	rred to medical					26. Plac	e of Death	1 ☐ Yes (Check only o	A No ne)	10	Yes	2/X] No	
> 5	hysician: his certific	To B	examiner? 1 ☐ Yes 🏋	7-	Hospital: 1 Inpatie		ER/Outpatier		4 K 1N		ne 5 🗆 Resid			Speci	fy)	
	Attending Physician: r death. ector: After this certific by the funeral director,	ion:	27. Manner of Dea 1 XNatural	th 5 Pending investigat	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Worl	yat k? Yes 2.⊑		8d. Describe h	now inju	ry occurred			
DIVISION	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral director.	ertification:	2 Accident 3 Suicide 4 Homicide	6 Could not determine	be 390 Place of Ini			reet, factory, office			8f. Location (S City or Tov	Street ar vn, State	nd Number (e)	or Aura	al Route Num	nber,
	e Hospite 24 hours e Funeral	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medicel Ex	Physicien: To the best eminer: On the basis o and manner st	f examinati	vledge, deat ion and/or in	h occurred at the tin vestigation, in my o	ne, date a pinion, de	nd place, ar ath occurre	nd due to the d at the time,	cause(s date and) and manne d place, and	er as s I due t	stated. to the cause(:	s)
	To the To the Complex	Me	29b. Signature and	title of certifier	AR.	11/1	A .	29c. Licens	e number			29d. Da	ite signed (A	Aonth.	Day, Year)	
)	\.			7	100	acre .	e VVI.	D247	21			De	cembe	r 1	2, 200)5
	10			ress of person wh	o completed cause of c			Print) wie Road,	Lau	rel M	אדו פודי	7				
	Sta	atè	31. Date filed (Mor					<u>`</u>	_uu.		2010 مير.	, ,				
	Regist		DE	C1320	32. Registr	200	1									

			1 - State Registrar Amend It.	State of N							_	giene Reg. No.	05	40166
	Dhysisi		1. Decedent's Name (First, Middle	, Last)	ı rnı 6	UCO	14/13	70 5	JII		2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Roosevelt	White							Novemb	-	2005	5:10A M
	Examir	er	4a. Facility Name (If not institution,	give street and number	er)		4b. City,	Town, or	Location of	of Death			County of Dea	
			Prince George	Hospital			Lan	ham				Pr	ince G	eorges
п	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. last	birthday) Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/24/	th ly, Year)	9. Bir	thplace (State or Foreign ountry)
Н	Director		229-64-2145 Usual Residence of Decedent		64	113.					12/24/	1940	Vir	ginia
	/land		10a. State 10b. County		10c. City, To	own or Lo	ocation	 -						10d. Inside City Limits
	Mary Fed	ţ	Maryland Prince	Georges	Сар	ito1	Heig	hts						1 ☐ Yes 2 XX
	n the	irec	10e. Street and Number				10f. Zip					10g. Citize	en of What Co	ountry?
	th wit	a D	7027 Onyx Court				2	0743	}			U.	S.A.	
	72 hours after death with the Maryland neturel', or Iteme 23a or 28a-f show dical Exarth at Invest be notified at	Funeral Directo	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13.	Was Deced	dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Ame	
98	or It		1 ☐ Never Married 2 🐴 Marri	ed 1 Yes 2] No		1 ☐ Yes		Specify:		riicari, stc./		Black, Whit	
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates	1964–6	0							Specify: B1	ack /
21215-0036	"net	Completed	15. Decedent (Specify only highes	s Education grade completed)	16	(Give	dent's Usua kind of woi DO NOT us	rk done o	turina mos	t of work	ing	16b. Kind	d of Business	Industry
7	withir ane. than	m l	Elementary/Secondary (0-12)	College (1-4o	r 5+)		stal		•			II.S.	Posta	1 Service
	filed Hygid ther ant, I		17. Father's Name (First, Middle, L	.ast)	<u> </u>					er's Name	(First, Middle,			I DELVICE
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Iteme 23a or 28a-f show any injury or other treumatic event, the Medical Exant activate be netified at once.	To Be	Edison Whit	:e							tha Co		arriame _/	
lan,	2 sho and ls ma reuma		19a. Informant's Name/Relationsh	-							I Route Numbe			
	l and lealth m 27 her to	0.	Patricia White	Wife						_	Heigh	_		
0	ges It of H		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Stat	e 20b. Place						Date		ation - City or	
ţ	t. Pa ntmen ntent: njury		'4 □Donation 5 □Other (Sp		Fort				_				twood,	
Baltimore,	permil Depar Impor Impor		21. Signature of Funeral Service L	ionseg							t Linco			
	GD2 6 0		23a Part 1. Enter the disease of	w							. Brent		, MD 2	0722 Approximate
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Dus to (or a	s a consequence		to		As	pira	tion pr	eumoi	nia	Onset and Death
O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	e of pregnancy 2 Fetal dea at time of death	ith 3	Ectopic pre					23	d. Date of del Month	very Day Year
۵.	hat th od by detacl		Part II. Other significant condition	as contribution to death	but not resulting	in the u	adoshina sa		a in Dard I		220 Dida			the cause of death?
ds,	signe d be	l by	Gasta	ntestin	^	1	C C	luse give	minranti.			es 2 🛣		obably 4 ⊟Unknown
Ö	w requir been si should	ete	1000	THE STATE	ru-			1 600	7		:			
Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Completed						-	/				24b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of
<u>=</u>	iciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Otho			Check only o		-	
ō	Phys rathis	<u>٩</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of In		Outpatien Time of		A Cuium	" 4 □ Nui	rsing Hor	ne 5 🗆 Resid	lence 6[Other (Spec	eify)
Division of	ding h. After fune	ţ	1 Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	M	Bc. Injury Work	at ′es 2.⊟N		ou. Describe r	iow injury a	occurred	
S	Attendi death. ctor: A y the fu	ertification:	3 ☐ Suicide 6 ☐ Could no	ot be	njury - At home,	farm stre			63 2 1	_	98f Location /9	Street and I	Viimher or Di	ral Route Number,
2	after after Direct	erti	4 ☐ Homicide determin	building, e	etc. (Specify)	· · · · · · · · · · · · · · · · · · ·	ot, lactory,	, onice			City or Ton	m, State)	vanious of Au	rai noute Number,
	Hospita 24 hours Funerel etely filled	Medical C	Check only 2 Medical E	Physician: To the bes	ot examination a	ge, death	occurred a	at the time	e, date and inion, deat	d place, a	and due to the o	cause(s) ar	nd manner as	stated.
	To the within 2 To the complet	Mec	one) 29b. Signature and title of certifier	and manner s	water.		200	Liconco	number			20d Date		D V 1
	F ≯ F 8) / mu	u i	71		1	n A A	くりつ	15		11-	24	, -ay, roary
	2	-	30. Name and address of person w	ho completed cause of	death (Item 22-) /Tuna	Print)	110	100	0 4	Im 1D 2	1 /	27	~)
	1)		72.02 Die S.	a lare	1 111	, tiype, l	77	100	0	3.	1 in	2.5	20	
	Sta	te	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	-	1001	· ·	-			0/	20	
	Registr		DEC 1 3 2	005	J. K.	600	des							

			1 - For State Registrar	State of Mar		partment of I		Ł	ne 05	40167
	Physi /Med		1. Decedent's Name (First, Middle, La Myrtle	Anna		Willey		2. Date of Death Month December	Day Year	3. Time of Death
	Exam Funera Directo	al l	218-03-7164	NGTON Medica	A CENTE In yrs. last birthda 85 Yrs.	R GLEN B		8. Date of Birth	(ear) 9. Birt	h CUNDO Inplace (State or Foreign untry) ryland
	e Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		oc. City, Town or Pasadena	Location				10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 24	Funeral Directo	10e. Street and Number 810 224th Street			10f. Zip Code 2112	22	100	g. Citizen of What Co U.S.A.	untry?
ILEY	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or Hems 23a or 28a-f show ont, the Medical Evantiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎖 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	er in U.S.	8. Was Decedent of H If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wi	
٠,	d 21215-0036 filed within 72 hours af Hygiene. ther than "natural", or on, the Medical Even	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) N/A	(Gi	eedent's Usual Occup ve kind of work done DO NOT use retire Homemal	during most of work d)	sing 16	6b. Kind of Business/	•
	Maryland 2 nd 2 should be filed tht and Mental Hygis 27 Is marked other r traumatic svent, II	To Be C	17. Father's Name (First, Middle, Last Joseph	F.	Нос	hler	18. Mother's Nam Mary	e (First, Middle, Ma	aiden Surname)	Gripp
h M	_ 5 = 0 -		19a. Informant's Name/Relationship (Thelma M. Ever		.)				City or Town, State, 2 Maryland	
	2 8 2 2 7		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Jeniloval Rolli State		position (Name of ematory or other plains) idge Mem.			oc. Location - City or $1 ext{kridge,} \; ext{N}$	
	Baltimo		21. Signature of Funeral Service Lice	Mins.		McCully-Po 3204 Mount	es of Facility Olyniak Fu tain Road	ıneral Ho		
•	Physicia /Medica		23a. Payr. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.	e death. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arres	wel	Approximate Interval Between Onset and Death
	Examine	r	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	donsequence of):	ema		- 1 /		
6	8 / 60, cate be executed physician and the burial-transit	Ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):	Renal	en fui	faile	se	
	SOX 6 ath certific ttending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐Ectopic pregnanc	у		23d. Date of delification	very Day Year
-	Cords, P.O. It wrequires that the despensioned by the a should be detached to	b	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause give	ven in Part I.	23e. Did toba	cco use contribute to 2 ☐ No 3 ☐ Pro	the cause of death?
<u>.</u>		Completed						24a. Was an autopsy performe 1 Yes 2 I	d?// prior to c death?	topsy findings available ompletion of cause of
	n of ng Phys After this uneral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manual of Death 1 Natural 5 Pending investigation		28b. Time	of 28c. injur	ner: 4 ☐ Nursing Ho	h (Check only one) me 5 Residenc 28d. Describe how	ce 6 Other (Specinjury occurred	ify)
	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined		· At home, farm, s (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	UNU To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examone)	nysician: To the best of m miner: On the basis of ex and manner stated	camination and/or	investigation, in my o	pinion, death occurr	red at the time, date	and place, and due	to the cause(s)
	5 Will Too	2	29b. Signature and title of certifier DALTITS-S	SAW HIKE	Yel	29c. Licens	14136	5	Date signed (Month $2/8/05$. Day, Year)
	2			wers Gla		Print) DAL	JIT S- Md 21	SAW HA	CEY	
	S Regis	tate trar	31. Date filed (Month, Day, Year) DEC 1 3 2005	32. Registrar's	Signature	Ses .		·		

		For State Registrar	State of M		d / Depa	artme	nt of H	lealth and I	-		005	40	168
Physicia /Medic	al	Decedent's Name (First, Middle, La A. Fecility Name (If not institution, given the second s	Clara	Whi	1by	4b Cib	, Town o	r Location of Death	2. Date of D Month 12	Day 9	Year 2005	4:	30 P M
Funeral Director		Future Care Old 5. Social Security Number 6.	Court 7. Ag		last birthday) Yrs.	Ra	nda1	Istown If Under 24 Hrs. Hours Min.	8. Date of B		Balto 9. Birth	place (St	ate or Foreigr
	ctor	Usual Residence of Decedent 10a. State 10b. County Md	N/A	10c. City	, Town or Lo	ocation			1-1-	-1903			de City Limits Yes 2 No
h with the 23a or 28	ai Director	10e. Street and Number 1701 Eutaw Place	:e			10f. Z	ip Code	21217			n of What Cor	untry?	
d 21215-0036 Illed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23e or 28e-1 ehow not, the Madical Examinar must be callified.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	,		Was Dec If Yes, sp 1 \(\text{Yes}		dispanic Origin? (Sl an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		Black, White		n,
Maryland 21215-0036 To 2 should be filed within 72 hours alf lith and Marial Hyginary 27 is marked other than "natural", or returnatic avent, the Mydical Event	Be Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 2nd grade	ade completed) College (1-4or	5+) I/A		dent's Us kind of w DO NOT esti		pation during most of wor d)	king		of Business/I	•	
ore, Maryland 212. ges 1 end 2 should be filed within t of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic avent, that M.	To Be C	17. Father's Name (First, Middle, Las Eliziha Holley 19a. Informant's Name/Relationship	")		19b Maili	na Addre	ss (Street	18. Mother's Nam Elva and Number or Ru				io Code)	
e, Mai 1 end 2 st Health and em 27 is r		Bessie Watford 20a. Method of Disposition		20b. P	243	0 W.	Co1c	lspring L		lto, N	1d 2121	.5	te
Pa Pa Int.		1 M Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Service Lice	ify)		ing Me	moria	al Pa	rk 12-	16-2005 March F			n, M	d
Balt permit. Departr Import. eny Inj		23a. Part1. Enter the disease, or cor	K. Am	es/	'		430	00 Wabash	Avenue	Balt		2121 Approx	
Attending Physicien: The law requires that the death certificate be executed redeath. Todasth. To should be detached for use as the burial-transit or buri	licai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence a consequence	uence of):	NA						Onset	and Death
P.O. Box 687 het the death certificate d by the ettending phy:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	⊒Ectopic ⊒ Other (:	pregnancy specify) _	y		230	d. Date of deli Month	very Day	Year
Cords, P.O. I wrequires that the deben signed by the esthould be detached?	ρ	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	inderlying	cause giv	ven in Part I.		Itobaccouse]Yes 2,⊠	contribute to		e of death? 4 ∐Unknown
Vital Recorradicion: The law requestricte has been rector, page 2 should	Completed								per 1 ☐ Yes	formed? 2 No	24b. Were au prior to d death? 1 ☐ Yes	topsy find ompletion 2 No	
of Vitalian hystoler hystoler his certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	I		ER/Outpatie	nt 3 🗆 🖸		4 Nursing H	th <i>(Check only</i> ome 5□Re		Other (Spec	ufy)	
Division of Vital Records, no the Hospital or Attending Physicien: The law requires the Within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	Certification:	27. Manner of Death 1 ANatural 2 Accident investigating	be On Discontin	jury - At ho	28b. Time of Injury	М		ryat rk? Yes 2∐No	28f. Location City or T		occurred Vumber or Ru	ral Route	Number,
Divisic To the Hospital or Attend within 24 hours after does To the Funeral Directors completely filled in by the t	ical Cer	(Check only 2 Medical Exa	hysicien: To the best	of my kno	wledge, deat								use(s)
To the I	Medical	29b. Signature and tille of certifier	and manner st	tated.		2	9c. Licens	se number		29d. Date	signed (Month	, Day, Ye	ar)
		1		M	n		PS7	722		12		12	200
\		30. Name and address of person who CONACO RULLAR 31. Date filed (Month, Day, Year)	completed cause of 2250p 560	2 BA	CTIMU	Print) RE N	VATION	IAL PILLE T	£603 (BALTIM	URE M	02	1228
Sta Registi		DEC 1 3 20	005	ara aigila	S South	We	î						

			For State Registrar	State of M	Maryland		artment tificate			ind M		jiene leg. No.	105	40169
			Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		James		Watkins	S					Dec 8,	2005	5	14:15 P M
	Examin		4a. Facility Name (If not institution						Location o	f Death			ounty of Deat	
			Southern Mary	land Hospit	al			Clin						eorge's
	Funeral Director		5. Social Security Number 364 34 3842	6. Sex 7. A	Age (In yrs. las	t birthday) 70 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb 9,	, Year)	Co	hplace (State or Foreign untry) higan
	pu *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Aaryla Poo	5		e George's			stvil:	۵1						1 ☐ Yes_2 ☐ No
	28a-	Directo	10e, Street and Number	e dearge b		1010.	10f. Zip					10g. Citize	n of What Co	
	Mith Ba or			ingdale Ave				20	747			Uni	ted St	tates
	ns 2	Funeral	11, Marital Status	12. Was Deceder		13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14	. Race - Ame	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itama 23s or 28s-f show aumatic event, the Medical Examinar must be maillised at	by Fun	1 ☐ Never Married		□™Korea	n	it Yes, spec 1 ☐ Yes 2		Specify:	, Pueno I	Rican, etc.)		Black, Whit	e, etc. Lack
21215-0036	2 hou	Completed	15. Deceden	it's Education		16a. Dece	dent's Usua kind of wor	Occupa	ation	t of worki	200	16b. Kind	of Business	Industry
215	hin 7 Bin "n Med	ple	(Specify only night) Elementary/Secondary (0-12)	st grade completed) College (1-4o	or 5+)	life.	DO NOT us	e retired)	O WOIN	ig			
21	o with	5	12			Comm	ınicat	tions		,,				- Air Force
D D	a = 0 \$	Be (17. Father's Name (First, Middle,	Last)							(First, Middle,	Maiden S	umame)	
<u>y</u>	Ment Ment arke arke	ဥ		atkins							npson			
Maryland	2 sh and is m		19a. Informant's Name/Relations		9		-				Route Numbe			
	l and leelth im 27 her t		Venice Watkins	(wife)	20b Plac						, Fores			20747 Town, State
0	Pages 1 nent of F int: if ite iry or ot		20a. Method of Disposition 1		te	netery, crei	sition (Nam natory or o	ther plac	e) De	ec 1	7 ^{te} , 2005			
Ë	t. Pa rtmen rtent: njury		4 Donation 5 Other (S		Arli	ingtor	n Nati	iona.	1 Cem	eter	y Tunonol			Virginia
Baltimore,	permit. Pages 1 and 2 should by Department of Heelih and Menta Important: If Item 27 is marked eny injury or other traumatic eng. 000.		21. Signature of Funeral Service	That M	0153		Alexar	ndria	a Fer	ry Re	oad, Cl	inton		6633 01d 20735
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cause only one cause on each	sed the death. n line.	Do not ent	er the mod	e of dying	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Cel	iehrol	VAS	cult	A	cide	nt				
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	nce of):								
Н	LAGIIIIICI	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ince of):								
	ed isit	ulne	cause. Enter Underlying Cause (Disease or injury	4	as a conseque	1100 01).								
	end end al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseque	nce of):								
760,	icate be executed physicien end s the burial-transit	calE		L _d										
89	ificate g phy as the													
ŏ	n cert	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnand		∃Ectopic pr	eonancy				23	d. Date of de	•
P.O. Box	death	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of dea		Other (sp						Month	Day Year
<u>Р</u>	at the	Phy	9 ☐ Unknown Part II. Other significant conditi		h hut not cocult	ing in the u	a dach ian a		on in Don I		230 Didte	abacco usi	a contribute t	o the cause of death?
Division of Vital Records,	The law requires that the death certifica ste hes been signed by the ettending ph page 2 should be detached for use as it	ed by	Part II. Other significant conditi	One contributing to death	TOUT NOT TO SUIT	ang an me u			OITHIT CALL			/es 2□		
eco	el o or	Completed									24a. Was autop	sv	prior to	utopsy findings available completion of cause of
= =	The Sete h	5										med? 24EtNo	death?	2 □ No
/ita	cian: ertific ector,	Be	25. Was case referred to medica examiner?	Hospital:				Oth	05		(Check only o			
of o	Physi this c	2	1 Yes 2 No	28a. Date of I	atient 2 E	R/Outpatie 28b. Time o			4 🗀 140		me 5 Residence R			ocify)
u C	Jing I	lo n	1 Natural 5 ☐ Pendi	/Adonth	Day Year)	Injury	м	28c. Injun Worl	k?¨ Yes 2 🗍		Loa. Bosonso .		0004.100	
isi	death death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	I not be	Injury - At hom	ne, farm, st							Number or R	ural Route Number,
≧	al or A s after il Dire	Certification:	4 Homicide		, etc. (Specify)						City or Tov	vn, State)		
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page.	Medical ((Check out) 2 Medice	ing Physician: To the be I Examiner: On the basi and manner	c of avaminatio	on and/or in	wastigation	in my o	oinion dea	ith occurr	ed at the time	date and r	viace and du	a to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of ception	èr			290	c. Licens	e number			29d. Date	signed (Mon.	th, Day, Year)
	~		Wallin T. O	me ky				735	206			Dec	ember "	7. 2ws
10	251		30. Name and address of person	who completed cause of	of death (Item 2	23a) (Type	Print)	n R	and	For	- WASH	you	mm	y/m/
	Sta Regist	ate rar	29b. Signature and title of certification one) 30. Name and address of person William T. T. 31. Date filed (Month, Day, Year	1 3 Z005 Reg	jistrar's Signatu	ire A	Spa	de la				1		,
	2. 1			9801	The section is		- 9							

		4	For State Registrar	State of Marylan		ent of Health and I ate of Death	Mental Hygien	
	Physicia		1. Decedent's Name (First, Middle, Last) EVELUA H.	Wallno	fer		2. Date of Death Month D	ay Year 8:32 A M
•	/Medic Examin	_	4a. Facility Name lift not institution, give st AHantic Genera	reet and number) A Hospito	,	Set 117		C. County of Death Norces Ho
35.5	Funeral Director		5. Social Security Number 6. Sex	M 200.F	last birthday) If Ui Mon	nder 1 Year If Under 24 Hrs hs Days Hours Min.	8. Date of Birth (Month, Day, Yea 3-11-22	
	aryland ehow d at	J .	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location	0.1		10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	or 28a-f	Director	10e. Street and Number	ter !	<u>() Co a</u>	Zip Code	10g. C	Citizen of What Country?
	er death w	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13. Was D	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puen	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	hours afte tural', or I	þ	1 Never Married 2 Amarried 3 Widowed 4 Divorced 15. Decedent's Educ	1 ☐ Yes 2 ♣No If Yes, Give Year or Dates:	1 ☐ Ye	s 2 No Specify:	16b.	Specify: White. Kind of Business/Industry
21215-	filed within 72 hours after death with the Maryland Hygiene. ither then "natural", or Itema 23a or 28a-f show int, the Medical Examinar must be notified at	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kınd o	f work done during most of wo IT use retired)	rking a	thome.
	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last)	hans	1 700.700		me (First, Middle, Maide	en Sumame) A.S.Ca. II.a. h
Maryland	and and is m	-	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailing Add	ress (Street and Number, r R	ural Route Number, City	or Town, State, Zip Code) H. M.D. 21842
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 try or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. F	Place of Disposition temetery, crematory	(Name of or other place)	1	Local on · City or Town, State
Baltin	permit. Pages Depertment of Important: If i any injury or once.		21. Signature of Funeral Service License		22. Nam		HTIMORE, N	10 21234. 0 HARFO ED 12D.
	 K-		23a. Part . Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the deat a cause on each line.	h. Do not enter the	mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	nal bleed	City	10 days
<i>2</i>	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):			
60,	ate be executed hysician and the burial-transit	icai Exar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):			
687	certificate Iding phys	edic	0					
165 O. Box	atter for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 0 0 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	al death 3 ☐ Ector	ic pregnancy r (specify)		23d. Date of delivery Month Day Year
17/4/8.	n requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the underly	ng cause given in Part I.		o use contribute to the cause of death? 2 PNo 3 Probably 4 Unknown
n/(No)/ DeD/ Record	w requi	leted	1	ellitus			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
	- m d	Completed	congestive	heat fo	uluse		autopsy performed	death?
$\frac{1}{2} \frac{1}{2}$	s certif	To Be	25. Was case referred to medical examiner?	ospital: 1 Tinpatient 2	ER/Outpatient 3[Othor	eath Check only one. Home 5 Residence	6 ☐Other (Specify)
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	iding Phy th. After this funeral c		27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
ングインタン シック Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa fy)	ctory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
	Hospita 24 hours Funeral etely filled	edical C	29a. Certifier 1 - Certifying Physics (Check only one) 2 Medical Examination	ician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death occu ation and/or investig	rred at the time, date and place ation, in my opinion, death occ	e, and due to the cause curred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	14		29c. License number	29d. I	Date signed (Month, Day, Year)
	J		Bustine C	Juffin,	MO	C1-00061	71 /10	1-11-2005
	5)	30. Name and address of person who co	mpleted cars of death (Itel	1 COAST	AL HIGHWA	14, FENUI	CK ISLAND, DE19914
F	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Spea	E)	,	
D	HMH 17 Rev 1/	*	What I did	The same of the sa	To last	Total .		

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylan			of Health a of Death		giene Reg. No.	05 4	0172
1	Physic /Medi		1. Decedent's Name (First, Middle, La	ast)	W		2194	TECE YVIK	Day	07 Year 2065	3. Time of Death
7	Examir	ner	4a. Facility Name (If not institution, gi	ve street and number)		Learning .	wn, or Location of		4c. C	ounty of Death	
		ĝ.		prins Hospit			timore			1/a	
	Funeral Director			Sex 7. Age (In yrs. 11⊠M 2□ F 53	**	If Under 1 \ Months D	Year If Under 2 lays Hours	Min. 8. Date of Birt Month, Da 2/26	/ 52	9. Birthpla Count Mary	ace (State or Foreign (Y) Land
	aryland •how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
	the Man 28a-feh	Director	Md n	/a	Balt	imore	ode		10a Citize	on of What Country	1⊠Yes 2□No
	38 or		6309 Brown Ave				1224			USA	,.
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. y			in? (Specify Yes or No- Puerto Rican, etc.)		Race - America	n Indian,
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Exemplar case by notified at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Cuban, Mexican, No Specify:	Puerto Rican, etc.)		Black, White, e	
5-0	be filed within 72 hours tal Hygiene. d other than "natural", event, the Medical Exp	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual C	ccupation	of working	16b. Kind	of Business/Indu	
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use r	etired)				
	filed with Hygiene other than	Cor	12	2		Tec	hniciar			Termin	ĹΧ
pu		Be	17. Father's Name (First, Middle, Las					's Name (First, Middle,		ımame)	
7 2	should be ind Menta imarked umatic ev	10	John Waybri	<u> </u>				ia Mille			
Maryland	O1 (0 as on		19a. Informant's Name/Relationship		1.			or Rural Route Numbe			
	s 1 and 2 if Health itam 27 l		Timothy M. Hoy 20a. Method of Disposition		lace of Dispos		enue 60	LOS Ang			
5	of of or		1 Burial 2 Cremation 3	Removal from State	emetery, cren	natory or other	r place)			tion - City or Tow	
Baltimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☑ Other (Special Signature of Euneral Service Lice					12/12/05			, Md.
Ba	permit. Pag Department Important: any injury o		21. Signature di Eurora Servica Elica	() P.				Funeral H			
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	plications that caused the death	n. Do not ente	ZUI D	undalk dving, such as c	Ave. Bal	t 1 MO		. 21222 Approximate
	Dhusisian		shock, or heart failure. List one	one cause on each line.			-,,	are as a respiratory an	001,	1 1	nterval Between Onset and Death
þ.,	Physician /Medical		disease or condition resulting in death)	a 5075(5						1	week
1	Examiner			Due to (or as a consequ	uence or):						
*****		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):				-		
1	uted d ansit	Examine	cause. Enter underlying Cause (Disease or injury that initiated events	C.							
ó	execting an an rial-tr		resulting in death) Last	Due to (or as a consequ	uence of):					_	
8760,	death certificate be executed eattending physician and of for use as the burial-transit	dlcal	(d							
9	ntifica ng ph as th	Jed	IT TENNI C								
Вох	leath certific attending pl	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregn	ancv		230	f. Date of delivery	,
	ie dea the att	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown		Other (specif				Month D	ay Year
P.0	ta by	by Physici	9 Unknown								
ŝ	Se Go		Part II. Other significant conditions	contributing to death but not resu	ulting in the un	derlying cause	e given in Part I.			contribute to the	V.
oro	w requires been sign should be	Completed						1UY	es 2 🗆 N	No 3 Probab	oly 4 Unknown
ec	or o or	nple						24a. Was a		prior to comp	sy findings available oletion of cause of
=	Th ale pag	Co						perfor	med?	death?	⊘ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					f Death (Check only or	ie.		
<u></u>		မ	1 ☐ Yes 2 No		ER/Outpatient			ing Home 5 Resid	ence 6	Other (Specify)	
Ž.	ling f	<u>o</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describe h	ow injury or	ccurred	
Sic	Attending r death. sctor: After by the fune	cat	2 Accident investigatio				1 Yes 2 No				
=	al or Al s after of I Dirac	Certification:	4 Homicide determined		me, farm, stre	et, factory, off	ice	28f. Location (Si City or Town	reet and N n, State)	lumber or Rural F	Route Number,
	To the Hospital or Attending Physical within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral directors.	edical (29a. Certifying Pt (Check only one) Certifying Pt 2 Medical Example 1	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the	ne time, date and ny opinion, death	place, and due to the c occurred at the time, d	ause(s) and ate and pla	d manner as state ace, and due to the	ed. Te cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. Lic	ense number	2	9d. Date si	igned (Month, Da	ıy, Year)
	C > F 0		Jan J	115		R	ES-0				
•	1		30. Name and address of pe on who	compand cause of death (Item	23a) (Type 5	Print)			CAAI	SEV UT	2005
	φ		Ery, Nwaneri	The Johns Hop	DKINS	H05-1-	0.000	00 D	ک مل	1700+ B)	128+
	Sta	te	31. Date filed (Month, Day, Year)	32. R. of trar's Signat	ure	Coull 1	1		.1- 0	, ,	anjora
	Registr	ar .	1151.13	/ 111111 PRE- 1 - 1	JE 195	160					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 WILLIAMS MARIAN 2005 **Physician** 12:47рм 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CLINTON Prince Georges SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) 11/20/1927 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) **Funeral** 1 □ M 2 💢 F 78 578-38-8186 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow event, the Medical Examiner must be notified at MD Prince Georges Clinton 1 X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6909 Friendship Road 20735 USA Items 23a by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, it a Medical Exam and ance. 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3

∭ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retined)
Teacher's Aide 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Special Education Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Torain Grace Joyce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harvey Williams, Jr. Son 3509 Maclefish Lane, Edgewater, MD 21037 20b. Place of Disposition (Name of cometery, crematory or other place)
Rivercale Park Crematory Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12/10/05 Riverdale, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bianchi 814 Upshur St Nw, Wash, DC 20011 23a. Part 1. Entertie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MYOCARDIAL ACUTE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown ۾ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HEART FAILURE CONSESTIVE 1 Yes 2 No 3 Probably 4 Unknown peen CERVICAL 24b. Were autopsy findings available prior to completion of cause of death? CANCER autopsy performed? 1 ☐ Yes 2 2 No certificate 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 24 hours after death.

• Funeral Director: After thietely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40324 12-4.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TERRY JODRIE, MD 7503 SURRATTS ROAD, CLINTON, MARYLAND 2073 [32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year WATKINS **Physician** 10:37 pm 2005 stirle December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KESWICK NURSING CENTER BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Months 1 □ M 2 🛛 F Director 84 1-11-1911 MARYLAND 214-40-5469 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: if iten 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other tranmatic event, the Modical Exercition mast be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1⊠Yes 2□No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code APT 454 21211 USA 830 W. 40th ST. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☑ Never Married 2 ☐ Married 1□ Yes 2☐ No Saltimore, Marvland 21215-0020 Specify: Specify: BLACK If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION -12--6-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VONZELLA JEFFERSON IRVING WATKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21211 W. 40 IH ST BALTO, MD EULA M. WATKINS (SISTER) Apr. 454 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Dispos 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 XOTHER (Specify) ENTOMBMENT ARBUTUS MEMORIAL PARK 12-12-2005 BALTIMORE, MARYLAND 4 Donation 21. Signature of Funexal Service Licensee JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Examiner ALBICANS Examiner CANDIDA attending physician end I for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown INSU FFICIENCY Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ 🕶 6 1 Yes 2 TNo or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) å Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 1 Tes 2 🗆 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital of 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) th Street Baltimore 830 WEST 40 DON M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 3

DHMH 16 Rev 6/95

			For Stete Registrar	State of	Marylan		artment of F			ental Hy	giene Reg. No	U U D I	+0175
			1. Decedent's Name (First, Middle	Last)		~				2. Date of De			3. Time of Death
	Physici /Medi		Donna	York			,			Decem	ber_	8, 2005	6:30 A ^M
	Examir	ner	4a. Facility Name (If not institution,		ber)		4b. City, Town, o		of Death		40	c. County of Death	
			Millenium Hea 5. Social Security Number		. Age (In yrs.	la at hirth day	Clint If Under 1 Year	0 # 4	24 Hrs	9 Date of Bi			eorge's
	Funeral Director		212 92 7357	1 M 2 F	43	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, Da June 3	ay, Year,	062 Mar	place <i>(State or Foreig</i> n n <i>try)</i> vland
			Usual Residence of Decedent		43		<u> </u>	1		oune 5	0, 1	902 Hai	yranu
	nylan how		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
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	with th	Director	10e. Street and Number	1. 5. 1			10f. Zip Code					itizen of What Cou	
	s 23g	erai	11. Marital Status	nultz Road		S 13	Was Decedent of h		igin? (Spe	orify Yes or N		ted Stat	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic avent, the Medical Examinar must be notified at ONGE.	by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford	ces?		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2☐,No	Specify		Rican, etc.)		Black, White	
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and	be fill	Be	17. Father's Name (First, Middle, L Donald Lan	ası) nier						(First, Middle $i111$ iam:		n Sumame)	
<u>₹</u>	should ind Men in marke	2	19a. Informant's Name/Relationsh			19h Maili	ng Address (Street					or Town State Zi	n Code)
Z	id 2 s Ith an 27 Is i		Don & Gail Lanie		6)		Schultz						,
อ์	tem (20a. Method of Disposition		20b. P	Place of Disp	osition (Name of matory or other place	Koau,	CII	ate		ocation - City or T	own, State
9	Pages nent of int: If it		1 ☐ Burial 2XXCremation 4 ☐ Donation 5 ☐ Other (Sp		late		atory Dec	1	2005		C1 :	nton. Ma	evlord
Baltimore,	permit. Departm Importal any inju		21. Signature of Funeral Service L		1 EC	2	2. Name and Addre	ss of Facili	Lee	Funeral	1 Hoi	me.Inc 6	633 Old
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			23a. art1. Enter the disease, or shock, or heart failure. List of	complications that ca only one cause in ea	used the deat		ter the mode of dyir	g, such as	cardiac o	r respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	He	Date	2 Gm	epholi	all	4				Onset any Death
9	/Medical Examiner		resulting in death)	Due o (o	s a consiq	uence of):	11	7)	0				
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Ć,	ate be executed hysician and the burial-transit	Exal	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):	Ciccir-	1	0000				
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9	certifical	Medi	IF FEMALE:										
Box	ires that the death certific signed by the attending p d be detached for use as I	Physician/Medical	23b. Was decedent pregnant	23c. If yes, outc 1□Live bir	ome of pregna th 2 ☐ Feta		∃Ectopic pregnancy	,				23d. Date of deliv Month	ery Day Year
0.B	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of d	eath 5[Other (specify)					Wichian	Duy Tour
\$ a.	The law requires that the death tte has been signed by the atter bage 2 should be detached for u		Part II. Other significant conditio	ns contributing to dea	ath but not res	ulting in the u	inderlying cause giv	en in Part	l.	23e. Did	tobacco	use contribute to t	he cause of death?
ds,	signe d be	d by	, <u></u>			_	,g g			10	Yes 2	No 3 □ Pro	oably 4 Unknown
7 0	w requir been si should	Completed								24a. Was	an .	24h Were autr	ppsy findings available
Rec	he lav	mp								auto perfe	psy ormed?	prior to co	mpletion of cause of
a le		e C	25. Was case referred to medical					26 Place	e of Death	1 Yes	24 No	1 ☐ Yes	2∐ No
Z =	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🛈 No	Hospital: 1 🗆 In	patient 2	ER/Outpatie	nt 3 DOA Oth	00 . /		Same and the same		6 ☐Other (Special	(v)
to	g Ph ter thi		27. Mann of Death	28a. Date of	Injury , Day Year)	28b. Time o	f 28c. Injur Wor	y at		28d. Describe			,
× :0	Attending r death. ector: After by the fune	atio	1 atural 5 Pending investig	ation	,,,	,,		Yes 2	No				
fax to	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Place of building	of Injury - At ho g, etc. (Specify	ome, farm, st	reet, factory, office		2	28f. Location (City or To	Street ar wn, State	nd Number or Run e)	al Route Number,
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	To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the beautien: On the base and manner	sis of examina	wiedge, deal ition and/or in	n occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and	 and manner as s d place, and due t 	stated. o the cause(s)
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	⊢ 3 ⊢ ŏ		1/ dem	ZMI	>		D-	245	35		1 2	2 08.0	5
	119		30. Name and address of person v	who completed cause	of death (Item	n 23a) (Type.			- /			, - 0 , 0	
1	4 '			. Berwa, N				Ave,	Suite	C 101	,Cli	nton, MD	20735
1		ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	iture	South 1						
	Regist		DEC 1	3 2005	Asses.	15	Joseph						
D11	MH 17 Rev 1/2	0001		7		1							

Physician

/Medical

Examiner

Funeral Director

or 28a-f show

Directo

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Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

if Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or i other traumatic event, the Medical Examinar must be n

permit. Pages I Depertment of H Important: If its eny injury or ot once.

Physician

Examiner

The faw requires that the death certificate be executed

or Attending Physician:

the Hospital

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within 24 hours after death To the Funeral Director: completely filled in by the

Division of Vital Records, P.O. Box 68760,

/Medical

attending physicien and for use as the burial-transit

been signed by the should be detached

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Richard	Patrick	_Abba jay	Jr.	S
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ck Abbaja; 1- Stata Registrar		State of	of Marylai	nd / Depa	artmen	t of F	leaith a <i>Death</i>	nd M	lental H	ygie Rag	P() ()	5	40176
1. Decedent's Name	e (First, Midd	le, Last)					-		2. Date of D	eath			3. Time of Death
Richard	Patr	ick Abb	ajay						Novemb	er	^{Day} 23, 20	005	5:15 A M
4a. Facility Name (I	f not institutio	n, give street and nu	ımber)		4b. City,	Town, o	r Location of	Death			4c. County	of Deat	th
7114 Lo	is Lan	e			Lá	anha	m				Prin	ce G	George's
5. Social Security N 220-50-6		6. Sex 1 💢 M 2 🗆 F	7. Age (In yrs. 45	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of B (Month, C June	ay, Ye		Çc	thplace (State or Foreign ountry)
Usual Residence of	Decedent						-						
10a. State	10b. County		10c. C	ity, Town or Lo	cation								10d. Inside City Limits
Maryland	Prince	George's	Lar	nham									1∭Yes 2 ☐ No
10e. Street and Nur	mber				10f. Zip	Code				10g.	Citizen of V	Vhat Co	ountry?
7114 Loi	s Lane				2070	06				U.	S.A.		
11. Marital Status 1 ሺ Never Marri 3 ☐ Widowed		If Vas Gi	Was Deced f Yes, spec	ofy Cuba	lispanic Orig an, Mexican, Specify:	in? (Spo Puerto	ecify Yes or N Rican, etc.)	0-		k, White	nican Indian, e, etc. Thite		
(Ѕрес	15. Deceder ify only highe	it's Education st grade completed)		16a. Deced	kind of wor	k done	durina most	of worki	ng	168	o. Kind of Bu	ısin <i>e</i> ss/	Industry
Elementary/Secon	ndary (0-12)	College (DO NOT us		d)						
17 Fathada Nama	(Einst Middle	1-	+	Ramp S	servi	ce				1	ited .		Lines
17. Father's Name (,					18. Mother	's Name	(First, Middle	e, Mai	den Sumam	e)	
Richard	Charle	s Abbajay					Patri	icia	Mae Z	ien	tara		

Completed by Funeral 17. Fathe Be

Ric 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Sharilyn Abbajay - Sister

7114 Lois Lane, Lanham, Maryland 20706

20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 12/02/2005 Silver Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses appresso / la

22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Complications

Approximate

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of)

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes

3 Probably 4 Unknown

24a. Was an autopsy performed? 12 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 Could not be

Hospital:

1 🗍 Inpatient 2 ER/Outpatient 28b. Time of Injury 28a. Date of Injury (Month, Day Year)

3 DOA 28c. Injury at Work?

Other:

1 ☐ Yes 2 ☐ No

111 Penn Street, Baltimore, Maryland 21201

4□ Nursing Home 5□ Residence 6 ②Other (Specify) Scene 28d. Describe how injury occurred

2 No

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

ath (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

OCME

November 23, 2005

31. Date filed (Month, Day, Year) State

NOV 2 9 2005

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEWS ER Year **Physician** ALBERTI DOMINICIE 24, 21:02 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS (to BICINS CITY 1 tospital BALTIMORE 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. WASHINGTON, 261-38-1417 74 JUNE 5, Director 1931 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other treumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No SUSSEX Directo DELAWARE BETHANY BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ERRETT ROAD 19930 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1953–55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne any injury or other treumatic event, the Medits once. Elementary/Secondary (0-12) College (1-4or 5+) MOVING & STORAGE PRESIDENT & FOUNDER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ LOUIS ALBERTI LOUISA CARMODY SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 ERRETT ROAD, BETHANY BEACH, DE. 19930 LAURETTA M. ALBERTA/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State DEL. VETERANS CEM. 11/29/05 ¹ 4 ☐ Donation 5 ☐ Other (Specify) MILLSBORO, DELAWARE 21. Signature of F 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 4 Part1. Inter the disease, or complications that caused #13 shock, if heart failure. List only one cause on and line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Description of the state of the Immediate Cause (Final DAY . SUBDURAL HEMORAHAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FALL Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P V VENTRICULAR DEVICE ASSIST 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HEART FAIWRE 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physicien: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending TRIP ON LEFT VENTRICULAR ASSIST DEVEE COLD 1 ☐ Yes 2 K No 07.00 AM 2 Accident investigation NOVEMBER 24, 2005 completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined HOME 5 ERRETT ROAD BETHANY BEACH, DE 19930 within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. KES - 000 24, 2005 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOON. WOLFE STREET, MD YING WEI LUM BALTIMORE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 18 **Physician** Byrd 2005 2:29 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges Months Days Hours Min. December 18 1963 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 F 579-94-8622 Washington, DC Yrs. Director 41 Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County i Health and Mental Hygiene. Item 27 is marked other then "neture!; or Iteme 23s or 28s-f show other traumatic event, the Medical Examiner must be notified as Prince Georges Forestville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 USA 6003 Parkland Ct. #202 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othe eny injury or other traumatic event 20c8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wade Byrd Gwendolyn Hamilton Ď 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meisha Byrd/ Daughter 6003 Parkland Court #202, Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY | 11/28/2005 SUITLAND, MARYLAND 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd., Landover, MD 20785 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician by ecist disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ettending physician and for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed? After this certificete funeral director, pag 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours efter death. To the Funeral Director: A completaly filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 117 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32800 MOV. 18,2005 Mary allyston 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) ingston Rd 4205 A Washington MD 20744 CT 31. Date filed (Month, Day, Year) Agistrar's Signature State NOV 2 9 2005 Registrar

Amend Item/17-19a, per inf, CSSU, 120 Pg. Figure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Amend item#20b, perfil, G852 Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 24, Pay005 Year 10:40 **Physician** BOGARD RUTH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center LaPlata, MD Charles If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 ☐ M 25 F Director 67 MAY 29 1938 MISSISSIPPI 425-78-4807 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in "natural", or itams 23a or 28a-f show Medical Examiner must be notified at 1 X Yes 2 ☐ No Director TENN SHELBY MEMPHIS 10g. Citizen of What Country? 10e, Street and Number 10f. Zio Code 1761 PRESTON STREET 38106 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ☐ Yes 2 ☑ No f Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LIBRARIAN ASSISTANT PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (Eirst, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental ! CLAYBORNE BROWN MATTIE BURDEN Τ., 19a, Informant's Name/Relationship (Type, Print) **Marie** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau -MARLE BANKS/DAUGHTER 3911 HEDGEMEAD COURT WHITE PLAINS MARYLAND 20695 20h. Place of Disposition (Name of 20a. Method of Disposition 12/6/2005 20c. Location - City or Town, State Comptery Crematory Southwoods 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State MEPHIS, TENN * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Senic Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 28a Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bacterema Physician /Medical Due to (or as a consequence of) Examiner Due to for as a consequence of Sequentially list conditions, any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 🗆 Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Malnutrition 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Is Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours e To the Funeral C The Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H-0042445 November 25 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Pimentel, DO, 601 Post Ofc. Rd., Ste. 1-A, Waldorf, MD 20602

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2085

. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Beattv : 35 Eva 3 2005 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Takoma Park Montgomery SLIGO CREEK NURSING HOME If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF Yrs. Director 2264 May 30 1930North Carolin 38 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is merked other then "netural", or have nother trainment. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYes 2 □ No Director D.. C Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 415 Rittenhouse Street, N.W. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married **Black** 1 ☐ Yes 2 No Specify: Specify: <u>≨</u> 3 TWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4years Special Education Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Will Small Lottie Coleman 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Rittenhouse Street, N.W. 19a. Informant's Name/Relationship (Type, Print) Cardella Beatty, daugther Washington, D.C. 2001 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 12/1/05 Landover, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 20001 621 Florida Avenue. NW. Washington D.C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the bunel-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last ete has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete has 1 Yes 2₽No 1 Yes 2 No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 ☐ Yes 2 No 1 🗆 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Yeheyis Negussie, M.D. 1111 Spring Street, Silver spring, Maryland 31. Date filed (Month, Day, Year) 2. Registrer's Signature State NOV 2 9 2005

DHMH 16 Rev 6/95

Registrar

1	sayan		State of	Mand	land / Department of	Hoolth and M	Anntal Hye	nio@oo) P*** 1	0	10
1-	For Amend State Registrar	Item	1&Unpend	Item	land / Department of 23a,27,28a-f Certificate o	r Death 6850	12-21-0	5 tas	15 !	ł U I	10

			1- For Amend Item 1& Registrar	Unpend It	em 23a,2	Certi	ment of real	Death a	850 12	11ai Hy 2-21-(gien)5 (1 Reg. N	as	40181
	Di		1. Decedent's Name (First, Middle, Last)	Patricia	A. Bava	h				Date of De Month		ay Yea	3. Time of Death
	Physici /Medic		PATRICIA		BAYAH					lovemb		27, 200	
1	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of	Death		4	c. County of De	ath
			I 495 N of Kenilwo	orth Ave.			Greenbel				I	rince G	eorge's
	Funeral Director		180-76-1762	7. Ag	e (In yrs. last birti 20		If Under 1 Year Months Days	if Under 2 Hours	Min.	Date of Bir (Month, Da L-18-	зу, Үөа	9. B FRI	irthplace (State or Foreign Sountry) SIFRR EETOWN, LEONE
· ·	tryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City Limits
	Sa-1-	cto	MD MONTGOME	RY	BURTONS	SVILI	LE						1 X Yes 2 ☐ No
	± 2 €	Dire	10e. Street and Number				40f. Zip Code				10g. C	itizen of What (Country?
	23.0	rai	3810 GATEWAY TERRA				20866					-	SIERRA LEONE
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Iteme 23a or 28a-1 ehow other treumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cub		in? (Specify Puerto Rica	/Yes or No an, etc.))-	Black, Wh	nerican Indian, nite, etc. BLACK
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21215-0036	d within Jiene.	Completed	Elementary/Secondary (0-12) 12th	College (1-4or	5+)		NOT use retire	d)	or working		PI	RIVATE	
B	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	irst, Middle	, Maide	en Sumame)	
<u>a</u>	Duid be Mental arked c	To E	KWAME BAYAH					CECILA	A FOBF	RUNSO			
Maryland	nd 2 should lith and Men 27 is marke r treumatic		19a. Informant's Name/Relationship (Ty CECILIA FOBRUNSO/MO			_	Address (Street ATEWAY T						
Baltimore,	Pages 1 e nent of Hei int: If item iry or othe		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State	Park of Gate of	AWIT	tion (Name of Park)	k ⁰	Date 12/10/	Ì	20c. Ro S 1 1	Location - City of CKVILLE Ver Spr	or Town, State , Md :ing, Marylar
Balti	permit. Pages Department of Important: If it eny injury or c		21. Signature of Funeral Service Licens	Lall		22.1	Name and Addre	ss of Facility	J.B.	JENK	INS	FUNERA	L HOME
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	e injurie a consequence c	es of):	une mode or dyn	ig, such as c	ardia o o re	spiratory a			Approximate Interval Between Onset and Death
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P.O. Box 6	The law requires that the death certificate be executed as thes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome 1 □ Live birth 4 ☑ Pregnant a 9 □ Unknown	2 Fetal death		ctopic pregnanc Other (specify)	у				23d. Date of d Month	elivery Day Year
	uires that signed b id be deta	þ	Part II. Other significant conditions con	ntributing to death b	out not resulting in	the und	lerlying cause giv	ven in Part I.		23e. Did t		11	to the cause of death? Probably 4 Unknown
Division of Vital Records,		Completed								24a. Was auto perfo		prior to death?	autopsy findings available o completion of cause of essential No.
/ita	ilcien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Januitali.			100		of Death (C	heck only o	one)		
7	Physicien: this certific ral director,	ျ	X Yes 2 No	lospital: 1 ☐ Inpati		·	3□ DOA Ott	4 🗆 1901	sing Home			6 Other (Sp	Scene
Ë	ling F After uner	Certification;	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıy Year) ir	ime of njury	28c. Injui	ryat rk?		. Describe	how in	ury occurred	
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Σ	or A offer Direction by	T.	4 Homicide determined	building, el	jury - At home, fai tc. <i>(Specify)</i>	rm, stree	et, ractory, onice		201:	City or To	wn, Sta	(e)T 495	North Of
u	To the Hospitel or Attanding Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one)		of examination and				place, and	due to the	cause(s) and manner	as stated.
	o the ithin : o the ymple	Mec	29b. Signature and title of certifier	and mainer st	<u></u>		29c. Licens	se number			29d. D	ate signed (Mo	nth, Day, Year)
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J.N.	/		30. Name and address of person who be Pamels E. South	all, mi)	111 Pe	nn S	Street,	Baltim	ore,	Mary1	and.	21201	
	Sta Registi		DEC 0 7 2005	2. Registe	rar's Signature	best	v						

Pamela E. Sandhall, M.

31. Date filed (Month, Day, Year)

DEC 0 7 2005 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Brunswick hanvel 11/9/man November 2005 US10 AM 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore e JUHN 7. Age (In yrs. last birthday) BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 121-30-0959 58 Yrs. Director Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "naturel", or items 23s or 28s-1 show the Medical Examinar must be notified at 1 Ves 2 No Director Castle Newark New 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Auckland Drive United States by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. ☐Yes 2 ☑No Yes, Give 'ear or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 onstruction arpente item 27 is marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 1 and 2 should be Health and Mental Drunswick Muriel Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 t DE A. wite Auckland Newark 19702 Brunswick Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)

Memoria Park 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State injury or ' 4 ☐ Donation 5 ☐ Other (Specify) 11-30-05 New Castle, DE 21. Signature of Fundral Service Licensee 22. Name and Address of Facility pnce P.O. any Wilmington, DE Congo Funeral Home 19805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final septic **Physician** Shock disease or condition resulting in death) Month /Medical Due to (or as a consequence of): Examiner bacterial endo carditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed Due to (or as a consequence of): real disease burial-tran and resulting in death) Last attending physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I Yes 2 No detached 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 10 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ So 24a. Was an page 2 s autopsy performed? Division of Vital 12 es 2 No Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No Depatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation by the 1 after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Res -000 Novambor 23, 2005 MD. CLD and address of person who completed cause of death (Item 23a) (Type, Print) Julie Lasman - John Hapkins Haspital, Tower 110 Jouton Loves, 600 North Wolfe Baltimore Manghand Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

NOV 2 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:54 A^M November 28, 2005 Alberta Bussard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7485 Belle Ridge Court Charles Hughesville If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2**K**] F Yrs. Oct. 8, 1942 Washington, DC Director 216-38-5320 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ?7 is marked other than "naturel", or Items 23s or 28s-f shor traumatic event, the Mudical Exonainer must be molified at 1 Yes 2X No Director Maryland Charles Hughesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a U.S.A. 20637 7485 Belle Ridge Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or Item eny injury or other traumatic event, the Mudical Exempted once. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Deward Phillipi Estelle Elizabeth Wedding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20637 19a. Informant's Name/Relationship (Type, Print) 7485 Belle Ridge Court, Hughesville, Maryland Kim Parker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns 12-01-2005 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. Box 156 M00053 Huntt Funeral Home Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage
Due to (or as a consequence of): Chronic Obstructive Pulmonary End disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Most Likely Malignan? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Confirmed 24a. Was an 2 No Division of Vital 1 Yes Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Uneck only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mana. D 50653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN . C SURANN

DHMH 17 Rev 1/2001

State

Registrar

Road Deale

Churchton

Deale

MOV 2 9 2005

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylan			nt of He te of D		l Menta	l Hygie Reg		5 4	0184
ı	Dhysici		1. Decedent's Name (First, Middle, Last)					2. Date Mor	of Death	Day '	Year	3. Time of Death
	Physicia /Medic		Helen Buor						Nov	ember	24, 2	005	12:30 P ^M
	Examin	er	4a. Facility Name (If not institution, give					ocation of De	ath		4c. County of		
			Manor Care-Chevy 5. Social Security Number 6. Se		last hirthday)		vy Cha	ase If Under 24 H	rs. R Date	of Birth	Mont	<u> </u>	Cy ace (State or Foreign
	Funeral Director		10	M 2☑F 84	Yrs.	Months		Hours Mi	n. (Moi	nth, Day, Y	ear)	Counti	y)
			156-03-9760 Usual Residence of Decedent	04			J		Apr	<u> </u>	91921	Ita	L y
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits
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2	12 sh h and 7 le m traum	Ĥ	19a. Informant's Name/Relationship (T)			•					ity or Town, S		رممور Land 20910
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e C	The law cate has b page 2 s	Completed	Dementi	2~					- 248	 a. Was an autopsy performe 	pr	ere autop: ior to com ath?	sy findings available pletion of cause of
<u>-</u>	i clan : The lav certificate has rector, page 2									Yes 2			2 2 (No
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	To t To t	Σ	29b. Signature and title of certifier				9c. License r				. Date signed		lay, Year)
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			30. Name and address of person who of Sunitha Bhogar	ompleted cause of death (Iter	n 23a) (Type,	Print)	0	C. 4	. , 2	de Care	Sau M	กวาะ	101
	C+	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature 🖋	1 12	rozio	Seet	72701		2010,00	. , 2-12	06
	Regist		NOV 2 9 20	32 Registrar's Signa	H. Alexander	ask.	P						

			For Stete Registrar	State	of Marylai	nd / Depa <i>Cei</i>	artment of I	lealth and Death	Mental Hy	giene () 5 Reg. No.	; 401	85
*	Physici /Medi		1. Decedent's Name (First, Middle Emelia G. Baqu		-				2. Date of De Month Novemb	er 25,	Year 2005 3:30	e of Death
	Examir	er	4a. Facility Name (If not institution 1901 Dayton St	reet			4b. Cily, Town, of Silver If Under 1 Year				gomery	
187	Funeral Director		5. Social Security Number 217-46-8161 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔼 F	7. Age (In yrs 94	Yrs.	Months Days	Hours Min	. (Month, Da	y, Year) , 1910	9. Birthplace (Sta Country) Cuba	te or Foreign
	e Maryland le-f show	ctor	10a. State 10b. County	ntgomery	10c. C	ity, Town or Lo	cation r Spring					e City Limits
	23a or 28	Funeral Director	10e. Street and Number 1901 Dayton Str	reet			10f. Zip Code 209	02		10g. Citizen of V US		
036	be filed within 72 hours after death with the Maryland stal Hygiene. Individual than "natural", or Itams 23a or 28e-f show of other than "natural", or Itams 23a or 28e-f show event, Ita Medical Examinar must be routified at	þ	11. Marital Status 1 □ Never Married 2 □ Mar 3 ♣ Widowed 4 □ Divorced	Armed F	2XINo ive		Vas Decedent of I f Yes, specify Cub ▼ Yes 2 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.) ban	Blac	e - American Indian ck, White, etc. ńite	,
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Baltimore,	Pages 1 annount of Hes	,	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Ga	Place of Dispo cemetery, cren	sition (Name of natory or other pla aven Cemeto	nce) Nov	Date 7. 29,	20c. Location -	City or Town, State	,
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k.	Physician /Medical Examiner	ner	23a. Part1. Enfer the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to huminediate cause. Enter Underlying	a. Rheu	caused the deal each line. Imatoid (or as a conse	Arthri		ng, such as cardia	c or respiratory ar	rest,	Approxin Interval Onset a 10 Y	Between nd Death
38760,	icate be executed physicien and s the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):						
P.O. Box 6	of the death certific by the attending parached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregr birth 2 Fet mant at time of nown	aldeath 3	Ectopic pregnanc Other (specify)	у		23d. Dat	te of delivery onth Day	Year
	law requires thet i as been signed by 2 should be deta	þ	Part II. Other significant conditions Congestive Hea					ven in Part I.			ribute to the cause	
al Records,	The page	Completed							24a. Was autop perfo 1 - Yes	rmed?	Were autopsy findin prior to completion o death? I U Yes 2 No	gs available of cause of
ion of Vital	Attending Physicien: T r death. ector: Atter this certificel by the funeral director, p.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	Hospital: 1 = 28a. Date (Mon	Inpatient 2 [of Injury oth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo	ner: 4 🗆 Nursing	Home 5 X Sesion 28d. Describe h			
Division	s after death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 208. Flac	e of Injury - At I ding, etc. (Spec	home, farm, str ify)	eet, factory, office		28f. Location (S City or Tox		er or Rural Route N	lumber.
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical one)		e best of my kn basis of examin nner stated.	nowledge, death ation and/or inv	occurred at the treestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the caus	:e(s)
)	Z com	Σ	29b. Signature of the title of pertine	77	MM	ND	29c. Licen:			•	d (Month, Day, Year	
	<i>ن</i>		T- 66 T- 3:		10801	Lockwo	ood Drive	e, #280,	Silver S	Spring,	MD 20901	
	Sta Regist		31. Date filed (Month, Day, Year)	2005	Registrar's Sign	nature	all s					

State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day NOVEMBER 2005 FRANC BALZER 24 9:50 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY CASEY HOUSE ROCKVILLE | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Young) | MAY 16 1911 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country)
 BRONX, NY **Funeral** Months Year) 1□M 20 F 117-03-0497 Director 94 Usual Residence of Decedent 10a. State 10c. City, Town or Location in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 21 No MD MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1799 EAST JEFFERSON ROAD, #119 20855 UNITED STATES OF AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 201 Married Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "nu any injury or other treumatic event, tre must once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EARLY CHILDHOOD EDUCATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALBERT ARONSON SOPHIE CHOSIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1799 EAST JEFFERSON ROAD #119, ROCKVILLE, MD 20854 ALEX BALZER, SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS LNEY, MD 11-27-2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. Wa 11000 NEW HAMPSHIRE AVENUE SILVER SPRING 11D 20904 23a. Part1. Enter the dilease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE CVA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sicien and e burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical the phys 98 use a IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Ď Month Day Year 5 ☐ Other (specify) ed by the a detached t 9 Unknown 9 ☐ Unknown sate hes been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) HOSPICE Hospital: မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Natural 5 | Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the eauso(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES HARRISON, M.D. 6001 MUNCASTER MILL ROAD ROCKVILLE MD 20854 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 29

2005

with the Maryland

death v

within 72 hours after

Maryland 21215-0036

ltimore,

The law requires that the death certificate be executed

P.0.

Division of Vital Records,

Physician:

or Attending

Hospite

To the

			For State Registrar	State	of Marylar			nt of H te of I		and M		giene Reg. No.	15 4	0187
	2		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		James W		Barron,	Sr.					Novemb		2005	6:26 AM
	Examin		4a. Facility Name (If not institution,	give street and n			4b. Cit	, Town, or	Location o	of Death			nty of Death	4
				nedical	Center		An	MPary	s, M				e Aru	
	Funeral			6.Sex 11 ∑ M 2□F	7. Age (In yrs.	last birthday) Yrs.	Month:	or 1 Year Days	/ If Under:	Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign htry)
	Director		081-03-3631 Usual Residence of Decedent	- A	88			L			Feb. 1	7,1917	New	York
	land ow		10a. State 10b. County	4	10c. Ci	ty, Town or Lo	ocation						1	Od. Inside City Limits
	Mary -feh	ţō	MD Anne	Arunde1	(Gambril	.1s							1 ☐ Yes 2 🛱 No
	1 the	Director	10e. Street and Number		L.		10f. Z	ip Code				10g. Citizen	of What Cour	ntry?
	death with the Maryland ms 23a or 28e-f ehow		1262 Defense H	ighway				210)54			U	SA	
	be filed within 72 hours after death with the Marylan at Hygiene. And thygiene. And there is natural, or items 23a or 28e-f show a check it is Marical Examiner must be mailised at	Funerai	11. Marital Status		cedent Ever in L		Was Dec	edent of H	spanic Orig	gin? (Spe	city Yes or No		lace - Americ	
٥	or its	Ī	1 Never Married 2 Marrie		2 No		1 🗆 Yes	•	Specify:	i, Puerto r	Rican, etc.)		Black, White,	
Ξ	urai',	d by	3 Widowed 4 □ Divorced	Year or	Dates: WWI]	-	103	2X.140	эрвену.			Зрв	cify: Wh	ite
9500-6121	within 72 hours after ene. then "natural", or ite tte Madical Exoluin	Completed	15. Decedent' (Specify only highest	s Education grade completed	1)	16a. Dece (Give	kind of w	ork done o	durina most	t of workin	ng	16b. Kind o	f Business/In	dustry
N	within ne. then	m	Elementary/Secondary (0-12)		(1-4or 5+)			use retired	,			17 a.d		_
N	e filed v al Hygie i other t vent, it		17. Father's Name (First, Middle, L	ast) 4		Chemi	.caı	Engli		r's Namo	(First, Middle,		neerin	g
and	ntal hed of	Be	James Henry Ba							ia Ti		Waller Sull	raine)	
Maryland	2 should be f and Mental H le marked of reumatic eve	2	19a. Informant's Name/Relationsh			19b Mailir	na Addre	s (Street :			Route Numbe	er City or To	en State Zin	Codel
<u>8</u>	s 1 end 2 should of Health and Men item 27 ie marke other treumatic		James W. Barro		Son)						olis,			, 6000)
อ์	Health tem 27 tother tre		20a. Method of Disposition		20b. 1	Place of Dispo	osition /N	ame of			ate		on - City or To	own, State
<u> </u>	ages ant of at: If i		1 ☐ Burial 2 ★ remation 4 ☐ Donation 5 ☐ Other (Sp		State	cemetery, crei				L - 28-	2005	Baltim	oro M	Th
Baitimore,	permit. Pages Department of H important: If Its eny Injury or of		21. Signature of Funeral Service L		rict		2. Name a	and Addres	s of Facilit	v			ore, n	<u> </u>
ñ	Depa impo eny ir		13- 2.C	eg-			Har	desty	Fune	eral	Home, Anna		MD 21	401
8	1 5.12		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the dea	th. Do not ent							1111 21	Approximate Interval Between
۰	Physician		Immediate Cause (Final	my one cause on	PNEVMO	1.4								Onset and Death
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	cate be executed obysicien end the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c										
Ď,	oe exection e		resulting in death) cast	Due to	o (or as a consec	quence of):								
9/60	cate to	dical	10	d										
٥ ×	certific nding p use as 1	/Me	IF FEMALE:	23c If yes o	utcome of pregn	ancy								
X P P	death of atten	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta	al death 3[Ectopic Other (pregnancy					Date of delive Month	Day Year
j	the d	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ U <i>n</i> k		36atti 5_	_ Other (.	specify/						
ř.	w requires that the death certific been signed by the attending p should be detached for use as	y Ph	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	inderlying	cause give	en in Part I.		23e. Did t	obacco use c	ontribute to th	ne cause of death?
ds,	uires sigr	d by	Dementin								10	res 2□No	3 Prob	ably 4 Dunknown
Cord	law rec es beer 2 shou	ompieted	[OCADAS.	ation 1	dicense						24a. Was	an 24	b. Were auto	psy findings available
ě	ifcian: The lay certificete hes rector, page 2	E C		way.	o such						autor	rmed?	death?	psy findings available mpletion of cause of
Vital	en: T	ပ	25. Was case referred to medical	<u> </u>					26 Place	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	2 No
	S w D	To B	exami <i>n</i> er? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 C	Othe			ne 5 ☐ Resid		Other (Specif	(v)
יס ר	ding Ph Ih. Atter thi funeral	L:uo	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Dat	e of Injury onth, Day Year)	28b. Time o	f	28c. Injun Won			8d. Describe			,,
0	ath. or; Af	atic	2 Accident investig	ation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	work? M 1 Yes 2 No							
DIVISION	r Att	Certificati	3 Suicide 6 Could no 4 Homicide determin	288. Pla	ce of Injury - At h ding, etc. (Speci	ome, farm, str	reet, facto	ry, office		2	8f. Location (: City or Tox	Street and Nu vn, State)	mber or Rura	l Route Number,
	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or													
								n, in my o	oinion, deat	th occurre	d at the time,	date and place	e, and due to	the cause(s)
	thin 2 the of the	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		2	9c. License	number			29d Date sin	ned (Moath	Day Year)
	5 1 <u>8</u> 1		At Mrs.					Done	6610			Norma	- 27	2005
			30. Name and address of person v	who completed on	use of death /line	m 23al (Tune	Print		0070	7		Mossin	1 1-1	
			TITUS ARRAHAM	An A	use of death (Itel Arund Bigistrar's Sign	Ped M	le di	al lo	nter	1	no All	· m.	1 211	ciny
200	Sta	te	31. Date filed (Month, Day, Year)	32.	gistrar's Sign	ature	-1	- 00			" y	1111	2/4	V/
- A	Registr	ar	MUV 28	2005	Malaca	K A	hours	8 .						

		State of Maryland / Dep		alth and N	lental Hyg	giene 05	40188
		Registrar Amended #19a perFH FCHD, KS 1. Decedent's Name (First, Middle, Last)	erinicale of D	eaur 11/	30/05 F	Reg. No.	3. Time of Death
Physicia		GERTRUDE V. BROOKS			Worth Weynha	Day Ye	205 7:34 PM
/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Le	ocation of Death	100	4c. County of D	eath
		Our family assisted Lining	mt. Où	y, M	D	Howa	rd
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 199–38–9072 1 M 2 F 97 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Sept. 3	y, Year) 9. 1908 P	Birthplace (State or Foreign Country) ennsylvania
and		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location				10d. Inside City Limits
Maryl	io	Maryland Howard Mt. Airy	y				1 ☐ Yes 2 ☐ No
r 28a	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What	Country?
th wit	alD	16350 Camalo Drive	21771			U.S.A.	
r dea	ner		 Was Decedent of Hisp If Yes, specify Cuban, 	oanic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	merican Indian, Vhite, etc.
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland in Hygiene. I have defent the matter from the mailfied at event, the Madical Extending from the mailfied at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ঐ No II Yes, Give 3 ※ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
2 hou	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupati ve kind of work done du b. DO NOT use retired)	ion ring most of work	cina	16b. Kind of Busine	ess/Industry
ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ing most of won	9		
led w tygier her th		17. Father's Name (First, Middle, Last)	Homemaker	8 Mother's Nam	e /First Middle	Own Home Maiden Sumame)	
ie, individed to it. 12.13.7. s 1 and 2 should be filed within 72 h l Health and Mentel Hygiene. Item 27 is marked other than "nature other traumatic event, the Medical	Be c	Samuel Elliot Echard		Phoebe J		•	
callyid	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and				e, Zip Code)
and 2: and 2: balth ai n 27 is		Kay Kost Kay Cost 1050	Henryton I	Road, Ma	rriotts	ville, MD	21104
item item		comptany c	position (Name of rematory or other place)		Date	20c. Location - City	or Town, State
Page ment eent: if ent: if		1 \(\text{Normal V i} \) 1 \(\text{Denation} \) 1 \(Denation	ille Cemete	ry 12/4	/2005	Springfie	ld Twp., PA
Daltimore, permit. Pages 1 an Department of Heali importent; if item 2 any injury or other once.		21. Signature of Funeral Service Licensee	OBERT E. DA	ATLEY &	SON FUN	ERAL HOME	S, P.A.
0.07.60		FILTS LOWER II	201 NORTH N	MARKET S	T. FRE	DERICK, M	D 21701 Approximate
		23a. Part . Enter the disease, or complications that the sed the death. Do not a shock, or heart failure. List only on the on each line. Immediate Cause (Final	sitter the mode of dying,	Such as cardiac	or respiratory ar	1031,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	172916				10 years
Examiner		Carrie A torre	Disease				20 4/100
	ner	Sequentially list conditions, if any, leading to immediate cause. Linter Unidorphic Cause (Disease or injury that initiated events	12730 1100				yatus
and trans	Examiner	Cause (Disease or injury that initiated events c					
f oU, e be executed rsician and e burial-transit	cal E	resulting in death) Last — Due to (or as a consequence of):					
certificate ding physise as the		d					
ox octi	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2 DEstania programa			23d. Date of	delivery
GOIDS, P.O. BOX 00100, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 Yes 2 KNo Compared to the past 12 months? 1 Pregnant at time of death 1 Pregnant at time of d	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
at the d by the etach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	a underhing equal quen	in Part I	23a Did to	phaces use contribut	e to the cause of death?
signer d be d	by	Hyperters in	a underlying cause given	intratti.	1 🗆 Y	- 4	Probably 4 Unknown
HECOTOS, he law requires t has been signe ge 2 should be	ompleted	- April - Silving			24a. Was	an 24b Were	autopsy findings available
VICAL MEC. siclen: The law certificate has b irector, page 2 sh	mp				autop	prior prior deat	to completion of cause of h?
VICAL iclen: T certificate ector, pa	C	25. Was case referred to medical		26. Place of Dea			Yes 2 To No
	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	tient 3 DOA Other	4 Nursing H	ome 5 Resid	dence 6 Other (5	Specify)
JI OT OT ding Phys	Di: T	27. Manner of Death 1 Senatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	y Work?		28d. Describe h	now injury occurred	
SIOI rendii eath. or: Ai	catle	2 Accident investigation		es 2□No	004 11' //	2	
JIVISION t or Attending after death. Director: After	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	street, factory, office		City or Tox		r Rural Route Number,
Hospite 4 hours Funerel ely fillec	edical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or					
To the I	Med	one) and manner stated. 29b. Signature and title of certifier	29c, License r	number		29d. Date signed (M	fonth, Day, Year)
F ≯F 8		18 Comin MID	75	764-	7	Novemb	28, 2005
13		30. Name and address of person who completed dause of death (Item 23a) (Type	pe, Print)		/		
12		Ernest Clevinger, J. MO 174 Thom.	as Johnson	Dr. Fre	derck, A	10 2170	クて
Sta Regist	ate rar	30. Name and address of person who completed dates of death (item 23a) (Type Fynest Clevings, Jr. MD 174 Thomas 31. Date filed (Month, Day, Year) 32. Register's Signature NOV 3 0. 2005	Spelle				

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	Dhysisi	20	1. Decedent's Name (First, Middle, Las	1)						ate of Death	ay Yea	3. Time of Death
	Physici /Medio		BRUCE NORMAN	BAKER						1 21	200	- 014
1	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location o	of Death	4	c. County of De	
			Peninsula Legioni	al medical	Center		Sali	Sbul	4		Wicon	nico
	Funeral		Social Security Number 6. Security Number	W	yrs. last birthday,	If Under Months	1 Year Days	If Under :		ate of Birth Month, Day, Yea	9. B	Sirthplace (State or Foreign Country)
	Director		488-44-1236	AM 2LIF 64	Yrs.		,-		YON	7.3,194		ISSOURI
	p a		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation						10d facile Ois Limits
	anyla ho	٦										10d. fnside City Limits 1 ☐ Yes 2 ☑ No
	Ne N	Directo	DELAWARE SUSSEX		REHOBOT							
	hours after death with the Maryland turel; or Iteme 23a or 28a-1 ehow al Examiner must be notified at		10e. Street and Number			10f. Zip				10g. 0	Citizen of What (Country?
	234	Funeral	4305 CAPTIVA SAN				9971				USA	
	er de	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deced If Yes, spec	tent of Hi offy Cuba	spanic Orig n, Mexican	gin? (Specify \ , Puerto Rican	fes or No- ı, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
36	rs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	959-	1 ☐ Yes	X No	Specify:			Specify WH	TTE
21215-0036	"naturel"		15. Decedent's Ed		979	dent's Usua	al Occupa	rtion		166		
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7	within ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+) 4		.NAVY					ILLITARY U.S. NA	
9	Hygi other	Ö	17. Father's Name (First, Middle, Last)		0.5	• IVA 1	NEI.		r's Name (Firs	t, Middle, Maide		<u> </u>
an	d ta b	00	HADOLD DAVED								,	
$\overline{\leq}$	d 2 should th and Mer 7 is marke treumatic	ို	HAROLD BAKER 19a. Informant's Name/Relationship (7)	vne Print)	19h Maili	na Address	(Street a		ICES CA		or Town, State	7in Code)
Maryland	ith an treu											_ `
-	Hea Heart		DANIEL BAKER/ SON 20a. Method of Disposition		b. Place of Dispe	sition (Nam	ne of		Date	IDGE, M	Location · City of	
õ	0 0 == =		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or of	ther place	1				
Baltimore	permit. Pag Depertment Important: I eny Injury o		4 □ Donation 5 □ Other (Specify	(1)	ELAWARE						LLSBORO	, DE
Bal	Depermine Deperm		21. Signature of the end Service Licent	M00866						& CREMA		
			23a. Part1. Enter the disease, or comp	mel						EWES, D	E 19958	
	Physician /Medical Examiner burial-transit the purial-transit	ical Examiner	disease or condition resulting in death) S. quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A S C A Due to (or as a cor Due to (or as a cor C. Due to (or as a cor Due to (or as a cor	nsequence of):			- far	retro			Mays
Box 6	death certifi e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3[Ectopic pre					23d. Date of di Month	elivery Day Year
	The law requires that the site has been signed by thi page 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying ca	ause give	n in Part I.	2	3e. Did tobacco	use contribute	to the cause of death?
Ę	quire n sig nd bu	pg p	CABG on	11/10/05						1 ☐ Yes	2 □ No 3 □ F	Probably 4 Donknown
9	w requii been s should	Completed		, ,					2	4a. Was an	24h Wara s	autopsy findings available
Re	The lay cate has page 2	Ĕ							- -	autopsy performed?	prior to	completion of cause of
a			25 Man ages referred to medical							□Yes 2201	o 1 ☐ Ye	s 20 No
₹		Be	25. Was case referred to medical examiner?	Hospital:			Othe	_	of Death Che			
ŏ	Phys this rat di	ပို	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time o		^	4 1401			6 ☐Other (Sp	ecify)
E C	Jing After fune	<u>o</u>	1 ☑Natural 5 ☐ Pending	(Month, Day Yea	r) Injury	M	Bc. Injury Work			escribe how in	ury occurred	
Division of Vital Records,	Attending r death. sctor; Aftel by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Blace of the				es 2□N				
\leq	after a	Ħ.	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.	At nome, tarm, sti pecily)	eet, factory,	, office		281. LC	ity or Town, Sta	ind Number or F te)	Rural Route Number,
_	urs a		00.0.45		WALES AND THE RESERVE OF THE RESERVE	NOT WARE	GCZC LICA	CONSIGNATION OF		nyo on there are a	vers two excessions	No in the last of
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exam	sician: To the best of my ner: On the basis of exar	mnuwladge, daet nination and/or in	vestigation.	in my op	e, dale and inion, deatl	place, and du h occurred at t	ie to the cause(he time, date ar	s) and marmer and place, and du	is stated.
	the the the	Med	one) 29b. Signature and title of certifier	and manner stated.								
	7 × 5 00	-	250. Signature diru title di certifier	Park			License			i	ate signed (Mor	
	14. D		Muchael V"	Jones		-	DO 2	203	8		21/05	
	120		30. Name and address of person who c					-		mi	charl P	Buchness
	.Mr		201 Pine Blu		Salis	bur	1_	71	218	01	10001	Buchness
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2	32. Registrar's S	ignature							

DHMH 17 Rev 1/2001

Bruce Baker 488-44-1236

	1 - For State Registrar		ryland / Dep Ce		of Healt of Dea		F	eg. No.	005	4019	0
ysician Medical	1. Decedent's Name (First, Mid Virginia	A.		Cantor			2. Date of Dea Month November		2005 Year	3. Time of 0	Death N
eral	4a. Facility Name (If not instituti Southern Maryland 5. Social Security Number 220–25–9424	Hospital 6. Sex 7. Age	(In yrs. last birthday	CI	inton 1 Year If Un Days Hou	der 24 Hrs.	8. Date of Birth (Month, Day	Year)		corge s	r Foreig
	Usual Residence of Decedent 10a. State 10b. Count Maryland Prince		10c. City, Town or t Oxon Hi				May 31,	1935	Phi	1ippines 10d. Inside City 1 Yes	
I Dire	10e. Street and Number 7404 Leyte Drive			10f. Zip	Code 10745			10g. Citiz US	ten of What Co A	ountry?	
any injury or other traumatic avant, the Madical Examinar must be notified at once. To Be Completed by Funeral Director		If Yes Give	ver in U.S. 13	Was Deced If Yes, spec			pecify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify:		
r, the Madical F	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed) College (1-4or 54	(Giv	edent's Usua e kind of wor DO NOT us lomemake	,	most of work	sing	16b. Kir	nd of Business In Home	ŕ	
To Be C	Andres Alcantar	a				Emili	e (First, Middle, a Leyva				
	Sonia Culi / Dat 20a. Method of Disposition			Leyte D	rive Oxo	n Hill,	Maryland Date	20	745 cation - City or		
once	1 ☐ Burial 2 ☒ Eremation 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service		Kalas Cre	matory		1	/2005 ge P. Kala		ewater, I neral Ho		
lical Examiner	Sequentially list conditions, farry, backing to innectiate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. lympt	consequence of):							unkno	Late
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at to 9 ☐ Unknown	Petal death 3	□Ectopic pre				2	3d. Date of del Month		ear
<u>۾</u>	Part II. Other significant condi	tions contributing to death bu	t not resulting in the	underlying ca	iuse given in P	art I.		bacco us		o the cause of de	
Completed							24a. Was a autops perform	med? 2 No	prior to death?	utopsy findings as completion of cal	vailab use of
To Be		Hospital:	t 2 ER/Outpatie	ent 3 DO			h <i>Check only or</i> ome 5 ☐ Resid		Other (Spe	ecify)	
Certification:	27. Manner of Death 1	tigation	ry - At home, farm, s	М	3c. Injury at Work? 1 ☐ Yes 2		28d. Describe h	ow injury	occurred Number or Ri	ural Route Numb)⊖r,
completely filled in by the tuneral director, page 2. Medical Certification: To Be Compl		ring Physician: To the best of al Examiner: On the basis of and manner stat	examination and/or i	th occurred a nvestigation,	at the time, date in my opinion,	e and place, death occur	and due to the c red at the time, d	ause(s) a ate and	and manner as place, and due	s stated. e to the cause(s)	
in con	> Rointan	Farah. 1			D 4 3 4				signed (Mont nber 27		
	30. Name and address of person PoiNTAN F 31. Date filed (Month, Day, Yea	ARAHIFAR	ath (Item 23a) (Type $M \cdot D \cdot QF$	Print)	organ Al	resuit.	3-41 Si	lvn	Spring	40 209	202

			For State Registrar	State	of Ma	ryland	/ Depa	artmen rtificate	t of H e <i>of L</i>	ealth a D <i>eath</i>	and Me	ental Hyg Re	iene g. No.	05	40	1191	
	Physicia /Medic		1. Decedent's Name (First, Middle, Hattie	Elizabe	eth	Car	ter					2. Date of Deat NOV • 23		005 Yea		Time of Deat	
	Examin		4a. Facility Name (If not institution, Holy Cross Re		ımber)					Location o				County of De			
	Funeral Director		5. Social Security Number 411 26 6165	6. Sex 1 □ M 2 🏋 F	7. Age	(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours		B. Date of Birth All Month, Day,	Yero 2	23 ^{9. B}	irthplace Country)	(State or For	əign
	yland sow		Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Lo	cation							10d.	Inside City Lin	nits
	he Mar 28e-f sh	ector	MD. Monts	gomery		Si1	ver S									1X∏Yes 2□	No
	23a or	al Dir	1001 Canyon I	Road				10f. Zip		20904		11	US. Citiz	en of What (Country?		
0500-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exaction in the notified and once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Der Armed F d 1 Tyes If Yes, G Year or	orces? 2 No ive			Was Deced f Yes, spec 1 ☐ Yes 2	ify Cuba	spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)		4. Race - An Black, Wh Specify: B	nite, etc.		
	n 72 ho "natur edical	leted	15. Decedent's (Specify only highest	grade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done a	luring most	t of working		16b. Kin	d of Busines	ss/Industr	ТУ	
717	ed withi ygiene. ser than t, the M	Completed	Elementary/Secondary (0-12)	none College	(1-4or 5+	+)	Beaut							ıty Sh	ор		
yland	uld be fil dental H rked oth tic even	To Be	17. Father's Name (First, Middle, L Robert Wadd	. '							a Per	First, Middle, A kins	Aaiden S	Sumame)			
Mary	id 2 shouth and N		19a. Informant's Name/Relationshi Altheia MARY Wyo		ight	er						Route Number, Silver					
more,	Pages 1 an nent of Heal int: If Item 3 iry or other		20a. Method of Disposition †□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Spi	3 □Removal from		20b. Pla	ce of Dispo netery, crer teran	sition /Nan	ne of	T	Da	te :	20c. Loc	ation - City o	or Town,		
Бапппо	permit. Departn Importa any injt		21. Signature of Funeral Service L Juan Sm:	auch	well	ESS.						ral Hom					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that nly one cause on a	PNE	the death. e. UMONI	Do not ent	O15 1 er the mode	2th e of dying	St] g, such as	V.F. I	Wash., D	est,	20017	2 M	proximate erval Between set and Death ONTHS	
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to		LURE conseque	TO TH	RIVE							2 M	ONTHS	
8/00,	icate be executed physician and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to	(or as a	conseque	nce of):										
DOX OD	certifica nding ph use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome o	of pregnance	су				 -		25	3d. Date of d	elivery		
Ö.	the death by the atter ached for u	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown		nant at t	2 ∏Fetal d lime of dea		Ectopic pre Other (spe						Month	Day	Year	
cords, r	law requires that the death certific as been signed by the attending p 2 should be detached for use as	by	Part II. Other significant condition DEMENTIA	ns contributing to	death but	t not result	ing in the u	nderlying ca	ause give	in in Part I.						use of death?	
ŭ L	8 2	Completed										24a. Was ar autops perform 1 Yes 2	y ned?	prior to death?	o comple	findings availation of cause	ble of
rvitai	ding Physician: The h. h. After this certificate he funeral director, page	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	Hospital:] Inpatien	nt 2 🗆 Ef	R/Outpatien	t 3 🗆 DO	A Othe			Check only one 5 ☐ Reside		Other (Sp	ecity) H	OSPICE	
on or	Attending Pt r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		of Injury oth, Day	Year) 2	8b. Time of Injury	M 21	Bc. Injury Work 1 □ Y	at ? /es 2 🗆 1		d. Describe ho	w injury	occurred			
Division		Certification;	3 Suicide 6 Could no 4 Homicide determin	200. Flat	e of Injur	ry - At hom (Specify)	ie, farm, str	eet, factory	, office		28	f. Location (Sti City or Town		Number or I	Rural Ro	ute Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) 1X Certifying 2 ☐ Medical E	Physician: To the xaminer: On the and ma	e best of basis of e	examınatio	edge, death on and/or in	occurred a	at the tim in my op	e, date and inion, deat	d place, an th occurred	d due to the ca I at the time, da	luse(s) a ate and p	and manner and du	as stated ue to the	i. cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	R	00				License 35996					signed (<i>Moi</i> 8 / 2005		Year)	
2	- (4)		30. Nome and address of person LINDA M. BURRE	completed cau	2730	ath (them 2	ÆKSTI	Print)BLV	7D.#4	400 W	HEATO	N,MD.20	902				
	Sta Registr	1.00	31. Date filed (Month, Day, Year) NOV 2 9 20	105 Se	Registrar	r's Signatu	ho	Ø.									

To Re Completed by E	sician/Medical Examiner	lication: To Be Completed by Physician/Medical Examiner
Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "naturel", or any Injury or other traumatic event, it a Mudical Exercitions.	the attending physician and sea as the buriat-transit	death. ctor: Atler this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours aft		ttending Physician: The law requires that the death certificate be executed
Baltimore, Maryland 21215-0036). Box 68760,	ision of Vital Records, P.O. Box 68760,

	_	For State Registrar			iviaiyiai	Ce	rtifica	te of E	Death	u ivie		Reg. No.	700	401	92
nysician Medical		1. Decedent's Name (First, Marcal Science Carolyn El	iddle, Lasi izak	•	Coachi	man					Date of De Month Ovem	Day			ne of Death 11:38 ⁴ A
caminer neral ector		4a. Facility Name (If not instit Washington 5. Social Security Number 577-58-5800	Adve	entist	Hosp 7. Age (In yrs.		Та	koma or 1 Year	Park If Under 24 H	eath Hrs. 8.	Date of Bir (Month, Da ug • 25	MC	County of Dea	ery	ate or Foreign
uffed at		Usual Residence of Deceden 10a. State 10b. Cou Md •				ty, Town or Lo		e							le City Limits Yes 2 \(\text{No} \)
the real Director		10e. Street and Number 7207 Donnel	.1 Di				10f. Z	p Code 2074	7				izen of What C		6
Exemple:	1	11. Marital Status 1 Never Married 2 □ 1 3 □ Widowed 4 □ Divor		12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 <u>⊠</u> No e		Was Deci if Yes, sp 1 🔲 Yes		spanic Origin? i, Mexican, Pu Specify:	(Specifi Jerto Ric	y Yes or No an, etc.)		14. Race - Am Black, Whi	te, etc.	n,
Important: It tem 27 te markee other than Thatuel, or tams 25s or 25s-1 show any Injury or other traumatic event, the Mudical Execution That be notified at 2005. To Be Completed by Funeral Director		15. Dece (Specify only hi Elementary/Secondary (0-1 Unknown		cation le campleted) College (1-	-4or 5+)	16a. Dece (Give life.	kind of w DO NOT	ork done du use retired)	tion uring most of a	working		16b. Ki	f-Emp	/Industry	
arked otheratic event,		17. Father's Name (First, Mid Richard E.		chman					18. Mother's N Elizal				Sumame)	10,700	•
n 2/ le ma ler trauma		19a. Informant's Name/Relat				+1120)1 R	hodei	nda Av	veni	120	er, City o	r Town, State,	Zip Code)	
tant: If Iter		20a. Method of Disposition 1 Burial 2 □ Cremati 1 □ Donation 5 □ Othe	r (Specify)			emetery, crer	natory or Me	me of other place m • Pa	ark 1	Date 2/2,	/05	La La	ndove	r, Mo	١.
any in		21. Signature of Funeral Sen	Edi	ware	W	39	910	Silv	er Hi	11	Rd.,	Sui	wards tland		
ician dical		23a. Paul 1. Enter the disease sbock, or heart failure. Immediate Candition disease or condition resulting in death)	e, or compl List only o	a. Sep	ich line.	<u> </u>	er the mo	de of dying	, such as card	diac or re	espiratory ai	rrest,			Between nd Death
rial-transit ran-transit ran-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to (c	irati(on Pne	eumo	nia						1 Da	У
for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 Total	2	d 23c. If yes, outc 1 □ Live bir 4 □ Pregna	come of pregnanth 2 Feta	ancy	Ectopic p	regnancy				2	23d. Date of de Month	livery Day	Year
d by Phys	•	9 Unknown Part II. Other significant con End Stage			ath but not res	ulting in the u	nderlying	cause giver	n in Part I.				se contribute to		
or, page 2 should		Hepatitis 25. Was case referred to median	С								24a. Was autop perfor	an esy rmed? 2 No	24b. Were au prior to death?		igs available
I direct		examiner? 1 Yes 2 Xo 27. Manner of Death 1 Xoatural 5 Per 2 Accident Inv	nding estigation	28a. Date o		ER/Outpatien 28b. Time of Injury		Other 28c. Injury a Work?	at Nursing	g Home		ience 6	Other (Spe	cify)	
filled in by the funeral Certification;		4 Homicide det	uld not be ermined	buildin	of Injury - At hig, etc. (Specif	y) 					City or Tou	vn, State)			lumber,
ompletely fill		(Check only one) 2 Medione)	cai Exami	sician: To the la ner: On the ba and mann	sis of examina	ition and/or inv	estigation	at the time n, in my opin c. License	nion, death oc	ace, and courred a	at the time, o	date and	place, and due	to the caus	
9		· Kal	ua	n K	ten	01		0196					e signed (Mont rember	,	
State Registrar		Dr. Raman F 31. Date filed (Month, Day, Y) NOV 2. 9	ar)	11, M		10810		nest	own Ro	d.,	Suit	e#2	02,Ga:	ther	sburg

			1- State of Maryland / Dep. Registrar Ce	artment of Health and M rtificate of Death		ene 05 g. No.	40193
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Frederick C. Cristofori, M.D.		NOV. 2	20 ^{Day} 2005	5:00 A M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			15003 Pear Tree Drive	Bowie		Prince	George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1	(Year) 9. Bir	thplace (State or Foreign
	Director		191–28–9196 ¹ X ^{M 2□ F} 71 Yrs.	World's Day's Tiours Will.	Oct. 6,	1934 Per	insylvania
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation			10d, Inside City Limits
	sho	'n					1 ☐¥es 2 ☐ No
	the A	Director	MD Prince George's Bowie	10f. Zip Code	10	g. Citizen of What C	
	with e or		15003 Pear Tree Drive	20721	10,	USA	buntry ?
	hours after deeth with the Maryland turel', or Items 23e or 28e-f show all Exanthernant be mullish at	Funeral		Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Amo	erican fodian
0	fler o	F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 📈 Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	
3	al', o	by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: V	White
9500-91212	be filed within 72 hours after deeth with the Marylan ital Hygliene. Id other then "natural", or items 23e or 28e-f show event, II a Madical Examinational barnolillad at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation skind of work done during most of worki	16	6b. Kind of Business	/Industry
N	thin and	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ng .		
N	ygier ygier yer th	Co	5+	Physician		Medical	
Maryland	I be filed within 72 h nial Hygiene. ed other than "natu : event, II e Medica	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)	
$\frac{3}{5}$	should by	L O	Florian Cristofori	Mary C			
Ma	12 sh h and 7 is n treum	14		ing Address (Street and Number or Rura			Zip Code)
	es 1 and 2 should b of Health and Ment I item 27 is marked r other treumatic e			3 Pear Tree Dr.	Bowie, MI	 20721 Location - City or 	Tour State
altimore,	permit. Pages Department of I Importent: If it any injury or or once.		125 build 2 Commation 3 Chamovat nom state	matory`or other place)			
	artme orten orten injury			la Cemetery 11/23		Monogahela	a, PA.
g	permit. Departr Importe any inju			512 NW Crain Hwy.	all Funer Bowie,		5
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
	Dhysisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ple myeiong			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	promewing			Zyeavs
	Examiner						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Exter Indextyling. Due to (or as a consequence of):				
	cuted	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			3	
Ď,	be executed sician and burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
8760	cate be executed physician and the burial-transit	dlcal	d				
9	ertific ling p	Φ	IF FEMALE:				
Box	the death certific y the attending p ached for use as	Physician/M		Ectopic pregnancy		23d. Date of de Month	livery Day Year
o.	the a	yslc	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			
٦.	that the de led by the a detached		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	sign sign d be	d by					robably 4 nknown
Ö	w requ	Completed			24a. Was an	045 14/	to a second final second secon
ě	The lav	du			autopsy	prior to	utopsy findings available completion of cause of
Vital	(0)	e Co	25. Was case referred to medical	00 Plant (Park)		<u> </u>	2 □ No
	ysicien: is certifica director,	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatie	26. Place of Death		ce 6 □Other (Spe	10 M 1
ō	ding Phy h. After thi funeral c	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at	28d. D. scribe how		Chy)
0	tending leath. tor: Aft the fun	atlo	1 XNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	I or Attend after death Director: /	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Ri	ural Route Number,
	rs aft el Dii	Certification;	Saliding, star (Spearly)		Ony or rount,	Sidio)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only check on the check only check only check on the check only check on the ch	th occurred at the time, date and place, a	and due to the cau	se(s) and manner as	s stated.
	To the P within 24 To the F complete	Medical	and manner stated.		r		
	o Twitl	-	29b. Signature and tipe of certifier	29c. License number		I. Date signed (Mont	
	Too		> Jelouil, us	017858		11/2/12	
2	(30)		30. Name and addr ss of erson who completed cause of death (Item 23a) (Type, STOAU+ E. SCIONICU, WO 90	D19838 O Bestgate Ra.	Anna	polis. 1	ua
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	,			
	Regist		NOV 2 8 2005	de			

AEM 05-07874 Charles Stephen Chatman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death	Reg. No.		
Cortificate of Dooth	2000	4013	J
State of Maryland / Department of Health and Menta	Hygienen n =	1.010	7

			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	40194		
	DI -		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death		
	Physici /Medi		Charles S. Cha	tmon				Novemb	er 22, 200			
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Deat		4c. County of De			
			S/B Rt. 210 + Farm	ning Rd		A	ccokeek		Prince	George's		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	Months Days		8. Date of Birti (Month, Day		Birthplace (State or Foreign Country)		
Japan	Director	Į .	Usual Residence of Decedent	207	40 Yrs.			Dec.06,	1964 Wa	shington		
	and		10a. State 10b. County		10c. City, Town or L	ocation				104 1044 00 11-0		
	Many!	ō	MD P.G.							10d. Inside City Limits 1 X Yes 2 ☐ No		
	288-	Director	10e. Street and Number		Accokeel							
	with with		1103 Pine Lane			10f. Zip Code	7		10g. Citizen of What	Country?		
	death with the Maryland me 23a or 28a-f ehow frittet be notified at	era		2. Was Decedent E	verin IIS 13	2060			J.S.A.			
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 le marked other then "natural", or iteme 23a or 28a-f ehow with figury or other treumatic event, the Macical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Tyes 2 No lif Yes, Give Year or Dates:		If Yes, specify Cult 1☐ Yes 2☑ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	o Rican, etc.)	Specify: B			
ှ ဂ	72 hc	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	ss/Industry		
7	thin	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retire	during most of wor ed)	king				
V	ygien riper th	ပ္ပ	1 2			lumber			Private			
yiand	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)			
<u> </u>	Men Men arke	မ	Charlie G. Chati				Bettie	J. Bui	nting			
е, маг	and 2 sh ealth and n 27 le m		19a. Informant's Name/Relationship (Type Veneta E. Chatmon		19b. Mail 1103	ng Address <i>(Str</i> ee B Pine I	and Number or Ru Lane Acc	okeek,	MD 206			
ם כ	of H of H if ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Disponentery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location - City	or Town, State		
Danimor	Pag meni lant:		4 □Donation 5 □Other (Specify)	mover moni state	Resurrct	ion Cer	n. 11/2	9/05 (Clinton,	MD		
	Departiment Departiment Important In Portant In In In In In In In In In In In In In		21. Signature of Funeral Service Deers e	0 .	2	2. Name and Addr	ess of Facility Ta	ylor's	Funeral	Home		
	Ø 0 ≥ € 0		P/3.C	uxol	17	722 N.Ca	pitol S	t.NW Wa	ash, DC 2	0001		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to e cause on each line	he death. Do not en	ter the mode of dy	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between		
1	Physician		Immediate Cause (Finat disease or condition	Mu	stiple	15 W.	VIP C			Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1	, , ,					
	Lxammer		Sequentially list conditions b.									
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
	and tran	cam	that initiated events resulting in death) Last									
Ŝ	cian cian ouria			Due to (or as a	consequence of):							
00/00	ertificate be executed ling physician and se as the burial-transit	Medical	d.									
o ≺	ding a	Me	IF FEMALE:	- 14	,							
	the Hospitel or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Exhours after death. The Funding Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	 c. If yes, outcome of the complex of the	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year		
Ŀ	that the ed by detac		Part II. Other significant conditions cont	nbuting to death but	not reculting in the	edeck in a second		00 0141				
Ŝ	sign d be	d b			not rosalling in the d	ndenying cause gi	on in Part I.			to the cause of death?		
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	a se	Completed						24a. Was a autops	n 24b. Were a	autopsy findings available completion of cause of		
2	cate pag	S						perform	ned? death? 2 ☐ No 1 🙀 Ye			
	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	and the la				h (Check only on				
5	Phys this al dir	J.	1 A 163 2 140	spital: 1 🗍 Inpatient		IL 3 DOM		me 5 🗆 Reside	nce 6 Other (Sp	ecity; At Scene		
=	ding P	Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo		28d. Describe ho	w injury occurred	2 9 665		
2	death death tor:	cat	2 Accident Investigation 3 Suicide 6 Could not be	11/22/10	6:39		Yes 2 No	suo pect	struce "			
2	or A after Direction by	E .	4 Homicide determined	building, etc.				28f. Location (Sti City or Town	reet and Number or F	Rural Route Number,		
4	pitel erel	Ö	29a. Certifier 1☐ Certifying Physic			eer		Farming	102 Rel	Accolerete MI		
	Hos 24 hc Fun stely	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ☑ Medical Exemine	on, On the Dasis of e	Manuficiation and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a	is stated,		
	To the Hospitel or Attending Physician: The within 24 hours after death, within 24 hours after death, completely filled in by the funeral director, paga	Med	29b. Signature and title of certifier	and manner state	Ju.	29c. Licens						
	+ 3 F 8		7/	o AC			- Turnuot		d. Date signed (Mon			
)	(17)		20 Normand address	MY		OCME			November 2	23, 2005		
_	(1)		30. Name and address of person who com				1+imomo	Mozer 1 1	21201			
½ <u>5</u>	Sta	6	31. Date filed (Month, Day, Year)	32. Registrar	11 Penn, S	rreer ba.	тешюге,	narytand	21201			
	Jia			- January Contract								

Registrar DHMH 17 Rev 1/2001 NOV 2 8 2005

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State of Maryland / Department of Health a Certificate of Death	nd Mental Hygiene OF LOIGE
Certificate of Death	Reg. No.
ist)	Date of Death Month Day Year
Cunningham	November 20 2005 1.20

Examine

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be nutified at any injury or other traumatic event, the Medical Examiner must be nutified at any injury or other traumatic event.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar	iicale oi Dealii	Reg. N	0.							
	Decedent's Name (First, Middle, Last)			Day Year							
i	Phillip Aaron Cunningham		November	20, 2005 1:30 P ^M							
r		b. City, Town, or Location of Death	4	c. County of Death							
144	University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign							
		Months Days Hours Min.	8. Date of Birth (Month, Day, Yea								
	Usual Residence of Decedent		March 4,	1989 Maryland							
	10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits							
2	District of Columbia Washin	gton		1X☐ Yes 2 ☐ No							
2	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?							
2	724 Whittier Street, NW	20011	Un	ited States							
10		s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I	14. Race - American Indian, Black, White, etc.								
2	1 Never Married 2 Married 1 Yes 2 No	1 Never Married 2 Married 1 Yes 2 No Yes 2 No Specify:									
npieted by Funeral	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:									
	(Specify only highest grade completed) (Give kir	nt's Usual Occupation and of work done during most of work!	ng 16b.	Kind of Business/Industry							
Ē.	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)									
3		Student	(First, Middle, Maide	Government							
ů û	17. Father's Name (First, Middle, Last)										
2	Unknown		A. Cunni								
		Address (Street and Number or Rura Street, SE #17 W									
	0			Location - City or Town, State							
	20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposit	1									
		Parker Cemt. 11/2									
		Name and Address of Facility ${\sf Stew}$ 1 Benning Road, N									
	23a. Part1. Sater the diseale, or complications that caused the death. Do not enter shock, in earl failure. List only one cause on each line.			Approximate Interval Between							
		L wound to the	hand	Onset and Death							
	disease or condition resulting in death) Due to (or as a consequence of):	wounds to the	neal								
ē	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):										
Examine	Cause (Disease or injury that initiated events c.										
	resulting in death) Last Due to (or as a consequence of):										
medical	d										
200	IF FEMALE:										
2	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ctopic pregnancy		23d. Date of delivery							
nysicia	1 Yes 2 No 4 Pregnant at time of death 5 C	Other (specify)		Month Day Year							
2	9 Unknown										
2	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.		use contribute to the cause of death?							
9			1 🗌 Yes	2 No 3 Probably 4 □Unknown							
Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
0			performed? 1 ¥ Yes 2 □ N								
90	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)								
0	1 1 No Hospital: 1 Pospital: 2 ER/Outpatient		ne 5 Residence	6 ☐Other (Specify)							
ii.	27. Manner of Death 1 □Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury Injury 28b. Time of Injury 28b. Time Injury 2b. Time Injury	Work?	28d. Describe how in	ury occurred subject was							
jati	2 Accident investigation 11/17/05 %100	ØM 1 ☐ Yes 2 Ø No	sho	i i							
erilli	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural R ute Number, te) 12LD b CF							
Medical Certification	29a. Certifier (Check only (C	occurred at the time, date and place, a stigation, in my opinion, death occurred	nd due to the cause ed at the time, date a	s) and manner as stated. Individual place, and due to the cause(s)							
меа	one) and manner stated. 29b. Signature and title of certifier	29c. License number	-J04 E	ate signed (Month, Day, Year)							
6	Parite Krishrell MA	OCME		vember 21, 2005							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Pr		NOV	CHIDEL 21, 2007							
	Pamela E. Southail, MD	111 Penn Street	Baltimore	e, Maryland 21201							
_											

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NOV 2 8 2005

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

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Division	

		_ For			epartment of F		-		40198				
		1 - State Registrar			Certificate of	Death		g. No.					
Physic		1. Decedent's Name (First, Middle, Last Margaret E.	Colling	gsworth	ı		2. Date of Death Month NOVEMBE	Day // Year	3. Time of Death 5 1520 M				
/Medi Exami		4a. Facility Name (If not institution, give				r Location of Death	TVUYCHIC	4c. County of Dea					
		THE MEMORII	AL HOS	PETAL	EI	ASTON		TALB	OT				
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birt	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	(gar) 9. Bir	thplace (State or Foreign ountry)				
Director		213-24-0544 Usual Residence of Decedent	JM 2DXF 76)	rs.		1/29/192	Mar Mar	yland				
land ow		10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits				
Man	to	Maryland Wicomi	co	Sali	sbury				1 Yes 2 XNo				
th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?				
72 hours after death with the Maryland naturel', or Iteme 23e or 28e-1 show digal Exeminar must be notified at	rai	304 Amherst Road			2180			USA					
er de	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ami Black, Whi					
irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X☐ No If Yes, Give Year or Dates:		1 □ Yes 🗶 No	Specify:		Specify:	white				
72 hour nature!		15. Decedent's Edu		16a.	Decedent's Usual Occup (Give kind of work done	ation	ing 1	6b. Kind of Business	/Industry				
- A	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	during most or work	ing						
be filed within tal Hygiene. d other then went, the Ma		11	_		Homemaker	40 Markeda Name	(Circa Adiadalla Ad	Domestic					
2 should be filled within and Mental Hygiene. Is marked other then aumatic event, Ital M	Be	17. Father's Name (First, Middle, Last) William Booth Ch	ristopher			18. Mother's Name Edith W	heatley	aiden Sumame)					
t and 2 should Heelth and Men tem 27 is marks	2	19a. Informant's Name/Relationship (T	_	19b.	Mailing Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)				
and 2 eelth at m 27 ie		Janice C. Colling	sworth/dau	ghter	5972 Tappan	Lane, Sa	lisbury,	MD 21801					
of He of He		20a. Method of Disposition	Pamaual from State	20b. Place of cemeter	Disposition (Name of crematory or other place	xe)		0c. Location - City or	Town, State				
Peges ment of ant: If its ury or o		1 🎖 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,		Sprinc	of crematory or other place hill Memory is	11/2	9/05	Hebron,	MD				
permit. Peges 1 and 2 Depertment of Heelth a Important: If item 27 is eny injury or other tra		21. Signature of Funeral Service Licensee) Holloway Funeral Home Professional As 501 Snow Hill Rd., Salisbury, MD 2180											
2		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	e death. Do n	ot enter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between				
Physician		Immediate Cause (Final disease or condition	Conel	no	1 and	Vien			Onset and Death				
/Medical Examiner		resulting in death)	Due to (or as a	consequence o	of):	*							
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uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Course			ten	Ry	eare					
te be executed rician and buriat-transit		resulting in death) Last	Due to (or as a d	consequence	(t):		1 0	`					
. 0 . 0	cal		02nd	SZ	rel -	rever	1 de	elone					
Meath certificate be attending physic	Physician/Med	IF FEMALE:			0								
ath co	lan/	23b. Was decedent pregnant in the past 12 ponths?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death	3 Ectopic pregnancy	1		23d. Date of de Month	livery Day Year				
the de	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4 Pregnant at tin 9 Unknown	ne or death	5 ☐ Other (specify) _								
s thet	by Ph	Part II. Other significant conditions co	entributing to death but	not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?				
quire an sign	ed b	Reighend	World	en c	Circore Co	2/ Gan	rene 1 - Yes	202No 3□P	robably 4 Unknown				
aw re	piet	Dealuter			,		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of				
The The ete ha	Completed						perform	ed? death?	2 No				
cian: ertific actor,	Be (25. Was case referred to medical examiner?	Managed (h (Check only one)					
Physic this c	2	1 ☐ Yes 2 ☑ No 27. Magner of Death	Hospital: 1 Inpatient			4 14013111g 110	me 5 Residen	ce 6 Other (Spe	ocify)				
After funer	to	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day)	(ear) Ir	njury Wor	k? Yes 2□No	28d. Describe 1104	virgury occurred					
Atten r deal	ifica	3 Suicide 6 Could not be	28e. Place of Injury	- At home, fai	rm, street, factory, office		28f. Location (Stre	et and Number or R	ural Route Number,				
s afte	Certification:	4 Homicide	building, etc.	(Specify)			City or Town,	State)					
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of eand mapner state	xamination and	, death occurred at the tir dor investigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner a e and place, and due	s stated. e to the cause(s)				
To the To the comp	M	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mon	th, Day, Year)				
. /2 -		10000	Solve	my	02:	3066		11/25/0	5				
10 pm		30. Name and address of person who co			Type.Print) ans Lane, Ea	aston, MD	21601						
St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 9 2	32. Raistrar		Sparke								
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			1 - For State Registrar		Stat	e of Ma	aryland / De		nent of H cate of I		mental Hy	GIOT Reg. N	UUU	40199
			Decedent's Name	(First, Middl	le, Last)						2. Date of De	ath		3. Time of Death
	Physici		Harold		Co1	eman					Decem:		2,200	5 18:52P M
3	/Medic Examin		4a. Facility Name (If	not institution				4b.	City, Town, or	r Location of Death		7	c. County of Dea	
1	E A GITTI	•	Southern	Mar	vland	Hosp	ital		Clint	on			Prince	Georges
	Funeral		5. Social Security Nu		6. Sex	7. Ag	e (In yrs. last birth		Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D			thplace (State or Foreign ountry)
	Director	ļ	578-54-4		1 3€ M 2□	JF	63 Yr	s.	Days	110013	Nov.1	Ź,	1942	Wash.,DC
	pu 🗼	- }	Usual Residence of I	Decedent 10b. County			10c. City, Town	or Location						10d. Inside City Limits
	eho.	5												112 Yes 2 □ No
	28a-f	ect	MD 10e. Street and Num		PG		Tem	~	H ill s f. Zip Code	3		100.0	Citizen of What C	31
	with	급	4103 27t		00110			'	2074	10				1
	eeth	Funeral Director	11. Marital Status	JII AV		Decedent	Ever in U.S.	13. Was [pecify Yes or N		ited S	
	r Hend	ᆵ	1 Never Marrie	d 21X Mar	Am	ed Forces? Yes 2 (XX)		If Yes	, specify Cuba	ispanic Origin? (Si an, Mexican, Puert	o Rican, etc.)		Black, Whi	
21215-0036	72 hours after deeth with the Maryland natural', or fleme 23a or 28a-f ehow disal Examinar must be motified at	Ď	3 ☐ Widowed 4		. If Ye	s, Give r or Dates:		1 🗆 Y	es 21X No	Specify:			Specify:	ack
Ö	2 ho	Completed	/Specif	15. Deceder	nt's Education	atad)	16a. D	ecedent's	Usual Occup	ation during most of wor	kına	16b.	Kind of Business	
21	within 7 ene. then "r	pje	Elementary/Secon		1	ege (1-4or 5		te. DO N	OT use retired	during most or wor.	King			
	filed wi Hygien other th	S	12				Car	pent	er			1	GPO	
nd	2 should be filed within and Mental Hygiene. ie marked other then eumatic event, the Ms	Be	17. Father's Name (f							18. Mother's Nan				
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Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f ehow other treumatic event, I're Medical Examinar must be redified at		19a. Informant's Nar				$\frac{196.1}{41}$	Mailing Ad	dress <i>(Street</i> 27th A	and Number or Ru venue	ral Route Numb	er, City	or Town, State,	Zip Code)
_	1 and 1ealth em 27 ther to		Lorraine		eman/w	rire	T'e	mple	. H111	s, Mary	land_2	207	48 Location - City or	
آور	Pages nent of I int: if its iry or o		1⊠ Burial 2 □	Cremation		from State	cemetery,	cremator	y`or other plac	·	12/0/01			
Baltimore,	rtme		4 □ Donation :				wasnin	_		Cem. 1				nd, Md.
Ba	permit. Pages 1 and 2 Depertment of Health a Important: if Item 27 is eny Injury or other tree		an	ice c	Edu	ruce	(3)			ss of Facility Ho ver Hill	_			Md.20746
			23a Part1. Enter the	e disease, o	r complications t only one cause	that caused	the death. Do no	t enter the	mode of dyin	g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between
4	Pnysician	7. 4	Immediate Cause (F	inal	(evo	11 3	hie	anl	anne	e+-			Onset and Death
1	/Medical		resulting in death)		a. D	ue to (or as	a cons suence of			al in	C .	0		
	Examiner		Sequentially list con	ditions.	b. 7	taut			vdu	al w	ard	70	1	
V	st sd	lne	Sequentially list con if any, leading to immorause. Enter Under Cause (Disease or in	nediate lying	₹ □	ue to (or as	a consequence of	:			Mireson			
V	and I-tran	Examiner	that initiated events resulting in death) Li		C	ue to (or as	a consequence of							
68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	a E				(,							
587	ificate g phys	edical			d									
Box	eath certing ettending for use a		IF FEMALE: 23b. Was decedent	pregnant			of pregnancy						23d. Date of de	livery
	w requires that the death cer been signed by the ettendin should be detached for use	Completed by Physiclan/M	in the past 12 m	nonths?	4	Pregnant at	2 □ Fetal death time of death		pic pregnancy er (specify)	<u> </u>			Month	Day Year
P.O.	t the by the ache	hys	9 Unknown		9[]	Unknown								
	gned gned	oy P	Part II. Other signific	cant conditi	ons contributing	to death b	ut not resulting in t	he underly	ing cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
rd	en sk	ed	U Hype	reas	(M C)	Ma	befer	rue	llite?	>	1 🗆	Yes	2 □ No 3 □ P	robably 4 Unknown
of Vital Records,	iaw re as be 2 sh	ple	(3) meta	State	ic fro	sta	te car	Ler	(D) A	nemig	24a. Was		24b. Were a	utopsy findings available completion of cause of
<u>a</u>	The ate h	NO.	(5) Chri	mic	Ren	al	Lin Suf	Rive	ulip		perf 1 ☐ Yes	ormed?	death?	s 2[X No
/ita	sian: ertific ictor,	Be (25. Was case referre	ed to medica	1.0				٦	26. Place of Dea	th (Check only	one)		
7	Physician: this certific ral director,	၉	1 ☐ Yes 2 ☐ X		Hospital:	1 Inpatie				4 Nursing n			6 ☐Other (Spe	əcify)
'n	After unerg	on:	27. Manner of Death 1 ⊠Natural	5 Pendi	ng	Date of Inju (Month, Day	ry Year) 28b. Tir y Year) Inj	ıry	28c. Injur		28d. Describe	how in	jury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident 3 Suicide	6 ☐ Could		Olono of Ini	ury - At home, farn	N		Yes 2 □No	29f Logation	/Cerone	and Number or C	ural Route Number,
Division	after Direction by	Certification:	4 Homicide	detem	nined 200.	building, et	c. (Specify)	1, 50000, 1	actory, office		City or To			urai nobile ivalitiber,
_	epita lours nerai	aC	29a. Certifier	1 Certifyi	ng Physician:	To the best	of my knowledge,	death occi	urred at the tin	ne, date and place	, and due to the	cause	(s) and manner a	s stated.
	To the Hoepital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)	2 Medical	Examiner: On	the basis of manner sta	examination and/	or investig	ation, in my o	pinion, death occu	rred at the time.	date a	nd place, and du	e to the cause(s)
	To t Com	Σ	29b. Signature and t	title of certific	000)			29c. Licens				Date signed (Mon	
			•	-01	AME	DOU	^		Doo	53941		1:	2/06/	2005
	10	1	30. Name and addre	ss of person	whi I Fermion	se of d	eath (Item 23a) (T	ype, Print)	/	. 00	40 .11	,	1101	2005 15 MD 20748
	10		31. Date filed (Monti	Mel h. Dav Year	prom	32. M gistr	ar's Signature	100	unab	ku haj	FD YV	arli	WHEIGH	(c m) 20448
	Sta Registi				3 2005	A	in the	1034	W				•	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 24, 2005 DUCKETT 1:03 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE PRINCE GEORGE HOSPITAL CHEVERLY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months | Days | Hours | Min. | MARCH | 14, 1925 | MARY LAND 5. Social Security Number 6. Sex 11 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Director 80 217-12-2342 Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or iteme 23a or 28e-f ehow ofical Examiner must be notified at 1 Yes 2 □ No Director PRINCE GEORGE BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8821 CHESTNUT AVENUE 20719 U.S.A. death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 21X Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene GOVERNMENT TRUCK DRIVER 2yrs traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental i marked JOSEPH DUCKETT FLORENCE HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DOROTHY DUCKETT/WIFE 8821 CHESTNUT AVENUE BOWIE, MD 20719 Health Item 27 I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1

Burial 2 □ Cremation 3 □ Removal from State 12-02-2005 VETERANS CEMETERY CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 EVTRICHAR **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien and Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Wunknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificete 2 No 1 Yes Attending Physician: director, Be 25. Was case referred to medica examiner? 26. Place of eath /Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DHG Certification; To 1 Inpatient 2 DER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation death. 1 □Yes 2 □No 2 Accident filled in by the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or At within 24 hours after d Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 20016197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 932 Aprom-Sover RD. My HA 31. Date filed (Month, Day, Year)
NOV 2 9 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygian | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** kerson -26-05 /Medical 4b. City, Town, or Location of Death 4c. County of Death Fecility Name (If not institution, give street and number) **Examiner** 1 comico DICE 0 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Yrs. 216-40-2622 **Director** 18, 1941 Maryland Usual Residence of Decedent with the Maryland or than "natural", or items 23e or 28a-f show the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 E. Elizabeth Street 21875 U.S.A. death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed withIn 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXXVo Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cashier 12 Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I Is marked Theodore Thomas Jefferson, Sr. Mary A. Sprague 19a. Informant's Name/Relationship (Type, Print) (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum 208 E. Elizabeth Street Frasure F. Dickerson, Sr 21875 Delmar, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery Dec. 1, 2005 Laurel, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATI CARCINOW. COLON Physician disease or condition resulting in death) YBAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it may be an all immediate cause. Enter Underlying Cause (Disease or injury Due to [or as a consequence of]: Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) this certificate has been signed by the ral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) HOSPICE 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/27/05 1005 5 2410 214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISISURY NO 2/801 WAR IS AFFOWEEDD CT. CHULAN 26266 Registrar's Signature 31. Date filed (Month 32. State 9 2005 Registrar B. Grante

DHMH 17 Rev 1/2001

ORIGINAL

			1- For State of Maryland /	Department of Health and M Certificate of Death	ental Hygier	20204 600
	Physici /Medic		1. Decedent's Name (First, Midelle, Last)		2. Date of Death	3. Time of Death
	Examin		4a. Fecility Name (If not institution, give street and number) AT LA	4b. City, Town, or Location of Death, ALISBURY	,	4c. County of Death W/COM/CO
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last I) Usual Residence of Decedent	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	57-1 1/01mm;
	Maryland -f show	tor	10a. State 10b. County 10c. City, To	REEN (1)00D		10d. Inside City Limits 1 ☐ Yes 2 No
	3s or 28s	I Director	10e. Street and Number 8384 - HICKMAN ROAD	10f. Zip Code	10g. C	Citizen of What Country?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, the Modical Examinational be multilized at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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yland	2 should be fill and Mental Hy ls marked oth aurmatic evan	To Be	17. Father's Name (First, Middle, Last) WILNER ELIAS	MARIE	(First, Middle, Maide	CHARLES
_	1 and 2 sh Health and 1em 27 ls m		MORANGE LARMERAN ~ UNCLE !	9b. Mailing Address (Street and Number or Rural	ISBURY N	1D 21804
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Bal	permit. Departr Imports any inju		21. Signatore of Funeral Service Licensee	22. Name and Address of Facility 3 &	ST SAL	MITH F/H USBURY MD 2180/
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (of as a consequence)	year Cancer	r respiratory arrest,	Approximate Interval Between Onset and Death MONTH
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)	Con With To	N	29b. Signature and title of certifier	29c. License number	8 29d. D	0ate signed (Month, Day, Year)
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	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2005 32. Posistrar's Signature	Small !		J'

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6	and lealth m 27		Nicholas James	Francis											d 20783
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ROX	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	aldeath 3□	Ectopic pregna						23d. Dat	e of delive nth	ry Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nant at time of down	ueam 5∟	Other (specify	v)							
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<u> </u>	Physician: The law this certificele has t ral director, page 2 s	Be (25. Was case referred to medical examiner?					2	26. Place of	of Death	(Check on				
	lysic lis ce dire	2	1 ☐ Yes 2 No	Hospitaf: 1 🔲	Inpatient 2	ER/Outpatien	t 3 DOA	Other:	4 👿 Nurs	sing Horr	ne 5□R	esidenci	e 6 🗆 Oth	er (Specify)
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury	28c. I	Injury a Work?					njury occurr		
DIVISION	Attending r death. ector: After by the funer	atic	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	,,,				s 2 N	0					
<u> </u>	or Atten efter deat Director; in by the	5	3 Suicide 6 Could of determined	ined 286. Place	of Injury - At h	ome, farm, str	et, factory, off	ice		2	8f. Locatio	n (Stree	t and Numb	er or Rural	Route Number,
5	s effer s effer al Dire	Certification:		ballo	ing, etc. (Speci	·y)					City of	Town, S	(ate)		
	Hospital or A hours efter Funeral Directly filled in		29a. Certifier 1 Certifyin	g Physician: To the	e best of my kno	owledge, death	occurred at th	e time,	date and	place, a	nd due to t	he caus	e(s) and ma	nner as sta	ated.
	To the Hospital or A within 24 hours effer To the Funeral Director Completely filled in by	edicai	(Check only 2 Medical one)	Examiner: On the b	asis of examina ner stated.	ation and/or inv	restigation, in r	ny opin	iion, death	occurre	d at the tim	ne, date	and place, a	and due to	the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifie.	5	. 0		29c. Lic	ense n	number			29d.	Date signed	(Month, E	Day, Year)
* 1	1+1		> mul	. Il	ul	M.D	D5	5536	52			No	ovembe	er 28	, 2005
Y	<i>J</i> ' '	}	30. Name and address of person	who completed cau	se of death (Iter		`								
			Irina Selya, M		. East J			et	Roc	kwil	1e. M	יכ חו	1852		
	Sta	te	31. Date filed (Month, Day, Year)					,	1.00.	· • • • ± ±	_C, P		5552		
	Registr		NOV 2 9	2005	Registrar's Signa	E ADD	West .								

			1 - For State Registrar	tate of Marylar		artment of He tificate of D			2005	40204
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yes	3. Time of Death
	Physici /Medic		Ruth D. Forsythe					November	26, 200	
	Examin	_	4a. Facility Name (If not institution, give stre			4b. City, Town, or Lo	ocation of Death		4c. County of D	eath
			The Annapolitan Assi				apolis		Anne Ar	
	Funeral		5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs. 94	Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. E	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent					Dec. 28,	1910	New York
Van	Mo M		10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
N	or 28a-f ehow se notified at	cto	Maryland Anne Arun	idel		Anı	napolis			1 ☐ Yes 2 , ☐ N o
with th	3a or 28 at be no	ai Dire	10e. Street and Number 84 Old Mill Bottom F	oad North		10f. Zip Code	1409	100	u. Citizen of What U.S.A	•
G K I K I 3-0000	i Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23a or 28a-f ehov other treumatic event, the Medical Examinar must be notified at	by Funeral Director		Was Decedent Ever in U Armed Forces? 1 □ Yes 2 % No If Yes, Give Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
5 Pol 22 Pol	"nature edical E	Completed	15. Decedent's Educati (Specify only highest grade co	mpleted)	16a. Deced	lent's Usual Occupation kind of work done dure OO NOT use retired)	on ing most of worki	ng 16	b. Kind of Busine	ss/Industry
	Department of Health and Mental Hygiene. Important: if item 27 ie marked other then eny injury or other treumatic event, Ira Ms once.	mo duc	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker			Own Ho	ome
	othe othe	Bec	17. Father's Name (First, Middle, Last)				B. Mother's Name	(First, Middle, Ma		
ad pa	Menta prked tice	ToE	James Diack				Rebec	ca Danie	ls	
should	and i		19a. Informant's Name/Relationship (Type,		1.00	g Address (Street and			•	
1 and	ealth m 27		Philip Forsythe, Jr			Presidents				
Pages	if ite		20a. Method of Disposition 1 Burial 200 Cremation 3 Rem	Svai iloili State		sition (Name of natory or other place)			c. Location - City	
	rtant		4 □ Donation 5 □ Other (Specify) 21. Signature of Timeral/Service Licensee	Ba		Cremator Name and Address				, Maryland
	Depa impo eny ir		Lord City Service City See	Tille						eral Home is, MD 21401
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of	ons that caused the dear	th. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arrest	AIIIapot	Approximate
	hysician /Medical		snock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	(gudia	c	Arylor				Interval Between Onset and Death
	xaminer		Sequentially list conditions, b	Due to for as a consec	ti	· Havi	me			
ted	nsit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	,				
icate be executed	physicien and s the burial-transit	Exal	that initiated events c resulting in death) Last	Due to (or as a consec	quence of):					
9 9	nysicie he bu	ical	d							
	ing pt e as ti		IF FEMALE:							
he death of	within 24 hours effer death. To the Funerel Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
that i	ned by deta		Part II. Other significant conditions contrib	uting to death but not res	sulting in the ur	nderlying cause given i	in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
Bouire	been sign	ted by						1 ☐ Yes	2 No 3	Probably Munknown
The law r	h. Atter this certificete has be funeral director, page 2 sh	Completed						24a. Was an autopsy performs	d2 death	autopsy findings available o completion of cause of ? es 2 No
Vician	certifi	Be	25. Was case referred to medical examiner?	utal:		Other		(Check only one)	Assi	sted Living
5 8	rah dii	2	10 163 20010	1 Inpatient 2	ER/Outpatien 28b. Time of	3 DOA		ne 5 Residence 28d. Describe how	e 6 28 Other (S	
	th. Fune	ê	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes	s 2 □No		injury occurred	_
Atte	octor by the	Hica	a Could not be	8e. Place of Injury - At h	ome, farm, stre	eet, factory, office	2	28f. Location (Street	et and Number or	Rural Route Number,
֪֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	ref Dir	Certification:		building, etc. (Speci				City or Town, S		
ne Hose	within 24 hours efter deal To the Funerel Director: completely filled in by the	edicai	29a. Certifier Certifying Physicia (Check only one)	n: To the best of my kno On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time, restigation, in my opini	date and place, a ion, death occurre	and due to the caused at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
Tot	To t	Σ	29b. Signature and title of certifier			29c. License na		29d	. Date signed (Mo	
			P//	-		D571	ひとる		11.28	· U5
			30. Name and a deress of person who comp Adition Umpra, M	D 600 Rid	gely A	ve. #231.	Anna	polis, N	10 2141)
	Sta Registr		31. Date filed Month, Day, Year) NOV 2 8 200	32. Resistrar's Signa	ature A	book				

		1 - For State Registrar	State of N	Marylan		artment of H tificate of		ind Mental	Hygier Reg.		4020)5
Physi	cian	1. Decedent's Name (First, Middle, Last)					2. Date Mont	of Death	Day Year	3. Time of	Death
/Med		Julia M. Ford						Nove		21, 2005	9:17	Ам
Exam	iner	4a. Facility Name (If not institution, give		•		4b. City, Town, o		_		4c. County of Deat		
		Ginger Cove Hea 5. Social Security Number 6. Se		er Age (In yrs. I	ast hirthday)	If Under 1 Year	nnapo		of Cieth	Anne Art		. po
Funera Directo			M 2€F	89	Yrs.	Months Days	Hours	Min. (Mon	th, Day, Ye.	ar) Co	hplace (State o nuntry) ryland	ir r-oreign
		Usual Residence of Decedent					1	Feb.	10,	1910 Ma	Lyrand	
rylan ihow		10a. State 10b. County			, Town or Lo						10d. Inside Ci	
Ba-f a	School	Maryland Anne Aru	ndel	Aı	mapol	1.5					1 🗌 Yes	2 X No
vith th	Director	10e. Street and Number				10f. Zip Code				Citizen of What Co	•	
s 23s	rai	4000 River Cresce			2 122	2140				ited Sta		
ter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force:	s?	5. 13.1	Was Decedent of I f Yes, specify Cub	an, Mexican	In? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race - Ame Black, Whit		
urs al	Ď	3√2 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s:		1□Yes 2√□No	Specify:			Specify:	hite	
d within 72 hours aff giene. er then "natural", or the Medical Exerni	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Dece	lent's Usual Occup	ation	of waddag	16b	. Kind of Business/		
ithin Mar	pldu	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	ic Affai:	d)		\ \n	larines		
LING X IX I 3-0030 be filed within 72 hours after death with the Maryland ital Hygiene. Id other than *natural', or items 23a or 28a-f ahow avant, the Medical Examinar must be notified at		12			Publ	ic Allai						
partition of the property of the control of the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, the Madical Examinat must be notified at	Be	17. Father's Name (First, Middle, Last) Alexander M. Tyree						r's Name <i>(First, M</i> Wh eele r		len Sumame)		
Mary fallo d 2 should be file th and Mental Hy ?7 la marked oth traumatic avant	P	19a. Informant's Name/Relationship (7)			10h Mailie	Address (Street	and Numbo	r or Pumi Pouto A	dumbar Ci	y or Town, State, 2	To Code	
and 2 sealth an n 27 le		Ellan Thorson/ day								nd 21401	up Code)	
F Hea		20a. Method of Disposition	8	20b. P	lace of Dispo	sition (Name of	1	Date	-	Location - City or	Town, State	
mit. Pages 1 ar partment of Hea portant: If item		1 ☐ Burial 2 XX remation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		(8)		natory`or other pla Cremato	· .	1-23-200)5 Re	ltimore,	Marv1a	ınd
permit. I Departm Importat	ė	21. Signature of Funeral Service Licens		/ ×			-			or Funer		
		1 Scott 1	Comeri	Du					_	nnapolis		-
Cate be executed /Medica Examine physicien and physicien and the burial-transit	1	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	as a consequal as a c	uence of):	an accia	lent				Onset and I	
the death certification by the attending grached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 5	Ectopic pregnanc				23d. Date of delivery Month Day				
w requires that been signed to should be detailed	2	Part II. Other significant conditions co	ntributing to death	but not resu	ılting in the ui	nderlying cause giv	en in Part I.	23e.		o use contribute to	4	
requ peen should	eted							_	1 Tes			Inknown
iclan: The law certificate has I	Completed							24a.	Was an autopsy performed Yes	e death?	topsy findings a completion of ca 2 No	available ause of
sicla certil	Be	25. Was case referred to medical examiner?	Hospital:		5510		er 1	of Death Check				
Phys arthis araldi	- To	27. Manner of Ceath	1 ☐ Inpa	njury	ER/Outpatien 28b. Time of	t 3L DOA	425 NUI			6 □Other (Speci jury occurred	city)	
nding tth.: After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	Day Year)	Injury	Wo	k? Yes 2∐1			,,		
i Sitte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office		28t. Loca City o	tion (Street or Town, St	and Number or Ru ate)	iral Route Numi	ber,
To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier TX Certifying Priy one) 2 Medical Exami	sician. To the bearings: on the basis and manner	ot examinat	wledge, dead ion and/or in	roccurred at the tile vestigation, in my o	ne, date and pinion, deat	place, and due to h occurred at the	o the cause time, date a	(s) and manner as and place, and due	stated. to the cause(s))
To th within To the	Me	29b. Signature and title of certifier	0.0			29c. Licens	e number		1	Date signed (Monti		
		> Thomaska	BUNI)		D23	867			11-23-	05	
		30. Name and address of person who co	ompleted cause of	f death (Item	23а) (Туре,	Driet)						
		THOMAS WAISH MD				m RUAD	me	NOW ML	21012	2		
Regis	tate trar	31. Date filed (Month, Day, Year)	005 32. R	strar's Signal	ture	Sant 1						

			1 - State Registrar 1. Decedent's Name (First, Middle, La	State of M	larylar	nd / Depa	artme rtifica	nt of H	ealth a	and M		Reg. N	-	5 4	020	6
	Physici	an		31/	CVD.	RETT					2. Date of De Month NOVEMB		74 .	20 ^Y /1 ⁸ 4	3. Time 0	
	/Medic	2.1	JAMES 4a. Facility Name (If not institution, given	e street and number		KEII	4h Cin	, Town, or	Location	of Death	NO VEND			ty of Death	00.12	_ A IV
	Examin		WASHINGTON ADVENT							OI Deall						
	Funeral		5. Social Security Number 6. S	ex 7. A		iast birthday)	If Unde)MA P	If Under		8. Date of Bi	rth		9. Birth	place (State	or Foreig
÷	Director		233-56-1460 Usual Residence of Decedent	ØM 2□F 6	58	Yrs.	Months	Days	Hours	Min.	JULY 2	I, rea	937	WEST	″∜IRGI	INIA
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation								10d. Inside (City Limits
	Ba-fs	cto	MD PRINCE G	EORGE	NEW	CARRO	LLTO	N							1 X Yes	s 2 No
	72 hours affer death with the Maryland "natural", or Rems 23a or 28a-f show idical Examinar must be notitled at	Funeral Director	10e. Street and Number					ip Code				-		What Cou	ntry?	
	ath w	rai	6109 87th AVENUE	Y			207					U.				
	ltem Item	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden	?	J.S. 13.	Was Dece If Yes, sp	edent of Hi ecify Cuba	ispanic Or n, Mexicai	igin? (Spen, Puerto	ecify Yes or No Rican, etc.)	0-		ice - Ameri ack, White,		
	irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	1 ZYes 2 ☐ If Yes, Give Year or Dates:	INO		1 🗆 Yes	2 X No	Specify:	:			Spec	ify: BLA	CK	
	z hou	ed	15. Decedent's E			16a. Dece	dent's Us	ual Occupa	ation			16b.	<u> </u>	Business/In		
		ple	(Specify only highest grant (0-12)	ade completed) College (1-4or	5.4)	(Give	kind of w	ork done d use retired	<i>luring m</i> os ')	st of worki	ing				,	
	n	Completed	Clementary/Secondary (5-12)	3yrs	3+)	TRANS	PORT	ATION	MANA	AGER		Pl	RIVA	TE		
	be filed tat Hygie d other event, t	Be C	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	First, Middle	, Maide	en Suma	тө)		
		2	EDGAR GARRETT						IDA I	BROWN	Į					
	d 2 shoutd th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Addres	s (Street a	and Numb	er or Rura	al Route Numb	er, City	or Town	n, State, Zij	Code)	
	C = N		JUNE GARRETT/WIFE		Tank.				UE NI		RROLLT	ON,	MD	20784		
	00==		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □	Removal from State		Place of Disponentery, cre	matory or	other plac			Date			- City or T		
	tant:	L	4 □ Donation 5 □ Other (Special	y)	MD	VETERA					-2005	CH	ELTE	NHAM,	MD	
	permit. Pag Depertment Important: eny injury o		21. Signature of Funeral Service Licer	ha (0	100		and Addres		JD	JENKIN NDOVER,	S FI	UNER 207	AL HO 85	ME	
5	Physician /Medical Examiner portal-transit	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a consec	quence of):	tic.	lvena	nany	148	ting,	Sis	e & L	e		
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Feta at time of c	al death 3[death 5[Other (s							ate of deliv		Year
	fures tha n signed I lid be det	ğ	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	ınderlying	cause give	en in Part I	l.			use cor 212 No		he cause of pably 4 []	
		Completed				-					24a. Was auto perfe 1 \(\text{Yes} \)			Were auto prior to co death? 1 \(\text{Yes}	ppsy findings impletion of a	available
	Physician: this certificatal director, a	Be	25. Was case referred to medical examiner?	Hospital:	-			Othe	200		Check only					_
		. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 □ Inpat		ER/Outpaties 28b. Time o		0	4 140	7 -	me 5 Res				(y)	
	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inj (Month, D.	ay Year)	Injury	м.	28c. Injury Work	ດ?ົ Yes 2 🔲		ZOU. DOSCINDO	HOW III)	ury occu	iii o u		
	i or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Ir	njury - At h	ome, farm, st fy)					28f. Location (City or To	Street a	and Num ite)	ber or Rura	al Route Nun	n <i>ber</i> ,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	dical	29a. Certifier (Greek only one)	lysicien: To the bes niner: On the basis and manner's	oi examina	owledge, deat alion and/or in	h occurre	d at the tim n, in my op	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and m	nanner as s , and due t	stated. the cause(s)
	within To th comp	Me	29b. Signature and title of certifier	// //			29	c. License				29d. D	ate sign	ed (Month,	Day, Year)	
			1-11	16	-			45	203	3		,	11-	2,-	7005	
1	(2)		30. Name and address of person who	comple cause of	l death (Iter	m 23a) (Type.	Print)						/	25	(00)	,
	9		STEPHEN SMITH MD					CKVT	LE.	MD 2	0850					
	Sta Registr	1	31. Date filed (Month, Day, Year) NOV 2 9 200	Regist	rar's Signa	ature					~~~					

			1- State of Man		irtment of H			giege 05	40207
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ıth	3. Time of Death
	Physici /Medic		Evelyn Lee Gambrell				Month	Day Yeer	005 21:40 ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	ath	4c. County of Dea	th
			Prince Georges Hospital	l Center	Chev	er1v		Prince	Georges
	, Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days		rs. 8. Date of Birtl	h 9. Bir	thplace (State or Foreign
prin.	Director		258-42-3206 1□M 2\\ 258-42-3206 1□M 2\\ 2	82 Yrs.	MOTHETS Days	Hours Mi	sept.	20 1022	GA
	pu ,		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo					
	anyla ehov	7	, , , , , , , , , , , , , , , , , , , ,						10d. Inside City Limits 1- Yes 2 □ No
	8a-f	octo	GA Fulton	Atlanta					
	hours after death with the Maryland tural', or Itame 23a or 28e-1 ehow al Examinar must be notified at	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	ath v	Funerai	517 Lynn Valley Road, St			30311		United	
	ar de tam	une	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
36	or l	by Fi	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☒ No		☐ Yes 25 No	Specify:		Specify:	
21215-0036	72 hours natural', dical Exe		3 ☑ Widowed 4 □ Divorced Year or Dates:	1 10 2				B1	ack
5	l within 72 ho liene. r than "natur the Madical.	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	ation fu <i>ring</i> most of w	vorking	16b. Kind of Business	Industry
7	within ene. then "	m	Elementary/Secondary (0-12) College (1-4or 5+)	_	trepren			Colf Emm	1000
	be filed tal Hygid d other event, t		17. Father's Name (First, Middle, Last)	111	crepren		ame (First, Middle,	Self-Emp	oloyed
au	ed lata	Be C						, , , , , , , , , , , , , , , , , , ,	
$\overline{\mathbf{z}}$	d 2 should th and Men 7 is marke traumatic	٦º	Embry Boggus 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	n Address (Street a	and Alumbarar	sey Unki	China Taura Chata	Zin Codo)
Maryland	d 2 sho th and t7 is m traum		Dwayne Preston/grandson	311	1 Eliza	heth I	da Driv	e	LIP COUR)
	s 1 and f Health Item 27 other to			20b. Place of Dispo cemetery, cren	nton, Mi	arylan	Id 2073	5 20c. Location - City or	Town State
Baltimore,	20= 5		Topural 2 Oremation 3 Demoval from State				126125		
量	permit. Pag Department Important: I any Injury c		4 Donation 5 Other (Specify) 21/Signature 1 Funeral Service Licensee	Lincoln			/26/05	Atlant	
Ва	permit. Pag Department Important: any Injury o		Signature 1 uneral service cicensee		. Name and Addres		_	Edwards	
e.			23a. Part 1. Enter the disease, or complications that caused th	a death De pat ent	910 Sil	ver Hi	11 Rd.,	Suitland	Md.20746 Approximate
			shock, or heart failure. List only one cause on each line.	e death. Do not ente	ar the mode or dying	g, such as cardi	A	rest,	Interval Between Onset and Death
Å.	Physician /Medical		disease or condition resulting in death)	noves	VIVa	long	trongs		
	Examiner		Due to (or as a c	o sequence of):	,				
		er	Sequentially list conditions h. h.	cen	1a	-			
	ted sit	nine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sequence or,	men	three	we les	1100	
	cate be executed obysicien and the burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a c	consequence of):		"/		e soon	
8760,	be e sicien buris	aiE	Char	mu c	Ren	al	Fail	une	
387	cate phy:	dicai	d				0		
×	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of	pregnancy					
Вох	atten for u	ian	in the past 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	ivery Day Year
o.	the d	Physician/M	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	ie or death 5	Other (specify)			-	,
0	that the di		Part II. Other significant conditions contributing to death but r	not resulting in the ur	iderlying cause give	en in Part I	23e. Did to	bacco use contribute to	the cause of death?
Records,	sign d be	d by	I he roam loss Cut	n va	10	_	1 🗆 Y		obably 4 Unknown
Ö	w requir been si should	Completed	1				-		
Sec.	e law has l	Idu	Ironema a				24a. Was a autop	sy prior to	topsy findings available completion of cause of
=		S	Encema lo	nas	his		perfor 1 ☐ Yes		2 💢 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medi 11 examiner?	, 4			eath (Check only or	nel	
of	Physiciu this cer al direct	2	1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient	2 ER/Outpatien		4 U Nursing		ence 6 ☐Other (Spe	cify)
		on:	27. Manner of Sath 1 Satural 5 Pending 28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurred	
Sio	Attending in death. ector: After by the fune	cat	Z Accident investigation 3 Suicide 6 Could not be 289 Place of Injury	3		res 2 □ No			
Division	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury building, etc. (At home, farm, stre 'Specify) 	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	ie Hospital or A 24 hours after ie Funeral Direc iletely filled in by								
	Hospital 24 hours Funeral tely filled	edical	29a. Certifier Check only Ch	camination and/or inv	occurred at the tim restigation, in my op	e, date and pla- pinion, death oc	ce, and due to the courred at the time, or	ause(s) and manner as	stated. to the cause(s)
	후 늘 후 음	Med	29b. Signature and title of Cepther	7	29c. License				
	S T Will		Soc. Signature and title or centrel	6.			205	29d. Date signed (Mont	Day, rear)
	1 7-		When I	5 gens	- 1/0	1027	200	11/18	101
1	4151		30. Name and address of person who completed cause of deal	th (Item 23a) (Type,	Print)	1 / 5	11		
				C) H	Print) DO	- cc	14161		
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2. 8. 2005	Signature	The same				

		•	T = For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of F	lealth and Death		jiene () 5	and the	020	8
	Physici		1. Decedent's Name (First, Middle, La Earl Lester Geis					2. Date of Dea Month Nov. 23	th	Year	3. Time of I	Death A M
	/Medic Examin		4a. Facility Name (If not institution, given Laurelwood Nursin	re street and number)		4b. City, Town, o E1kton	r Location of D		4c. County		11.7.5	
	Funeral Director			Sex 7. Ag	e (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Birth fin. (Month, Day Feb. 25	, 1928 1	9. Birthpla Countr Penns	ice (State or y) y1vani	Foreign La
	Maryland	ctor	10a State PA 10b. County York		10c. City, Town or Lo	cation				100	d. Inside Cit	•
	3a or 28	i Director	10e. Street and Number 3400 Eastern Blvo	1		10f. Zip Code 1740	2		10g. Citizen of W		y?	
9000	thin 72 hours after death with the Maryland e. an "natural", or itams 23a or 28a-f show Mudical Exain as must be indiffed at	d by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 TYes 2 If Yes, Give Year or Dates:	Notoro			(Specify Yes or No- uerto Rican, etc.)		tates - America k, White, et - White	tc.	
Maryland 21215-0036	I within 72 iene. r than "na	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 8	ade completed) College (1-4or	(Give	dent's Usual Occup kind of work done DO NOT use retired Buyer	during most of		Steel		ıstry	
/lanc	be be	To Be	17. Father's Name (First, Middle, Last Earl Lester Geist					Name (First, Middle, i ine Sarah		,		
Mary	s 1 and 2 should f Health and Mer itam 27 is marke othar traumatic		19a. Informant's Name/Relationship (Thomas Beman/son				and Number or	Rural Route Number th East, N	r, City or Town, S	State, Zip C	Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: if item 27 i any injury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Removal from State	20b. Place of Dispo cemetery, cren Heiland V	sition (Name of natory or other place iew Ceme	Nov tery	ember 28, 2005	20c. Location - 0 Red Lion Pennsy 1	^{City or Tow} n vånia		
Balt	permit. Departi Importi any inj		21. Signatur Fu eral Service Lice	2	12	7 South 1	Main St	rouch Fune reet, Nort	eral Hom th East,	ie		
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aCAN C	a consequence of):			81		1	Approximate nterval Betw Onset and D	veen .
	Examiner	<u></u>	Sequentially list conditions,	b. cmic	a consequence on.	STATE	64nd	D		3	Pn	pi6
8760,	rate be executed thysician and the burial-transit	ai Examine	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c i 4720 21	a consequence of):	THE PU	1 and WA	ny 415%	15£	7	usn.	·\$.
.O. Box 687	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy			23d. Date Mon	of delivery		ear
٥.	signed d be de	by	Part II. Dther significant conditions	contributing to death b	ut not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contri		cause of de	
al Records	The ate h page	Completed						24a. Was a autops perform	ned? de	rior to comp eath?	sy findings a pletion of car	vailable use of
i Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2□ER/Outpatien	t 3 DOA Cth		Death <i>Check on on</i> g Home 5 ☐ Reside		r (Specify)		
Division of	i or Attending Ph after death. I Diractor: After thi d in by the funeral	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury			28d. Describe ho	ow injury occurre	ed .		
DIVI	s after d	Certifi	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (St City or Town		r or Rural F	Route Numb	er,
	To tha Hospitai within 24 hours a To tha Funarai I completely filled	edical	(Check only 2 Medical Examone)	ny sician: To the best miner: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	occurred at the tin restigation, in my o	ne, date and pla pinion, death or	ace, and due to the caccurred at the time, d	ause(s) and man ate and place, ar	nner as stat nd due to th	ed. he cause(s)	
	To t To t	Σ	29b. Signature and title of certifier Aulandale	Carre		29c. Licens	*7 4 6 -		9d. Date signed			
2	+1'		30. Name and address of person who	Sheet	leath (Item 23a) (Type,	Print)	91921					
	Sta Registi		31. Rate filed (Month, Day, Year) 2 9 2005	32. Registr	ar's Signature	1011						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 15

			1 - For State Registrar	State of	Marylan				lealth ai D <i>eath</i>	nd Me	ental Hy	gjen	00	40209	
			Decedent's Name (First, Middle,	Last)						2	2. Date of D			3. Time of Death	-
н	Physici		Harry Clement (Two						Month	Da		/ - 00 DM	
	/Medic Examin		4a. Facility Name (If not institution,				4b. City	. Town, or	Location of		ovemb		2, 2005 c. County of Dea		-
1		ler	321 Fletchwood H		,				2002(10)70						
	Funeral				7. Age (In yrs.	last birthday)		ton er 1 Year	If Under 2	4 Hrs. g	B. Date of Bi	rth	ecil 9 Bi	rthplace (State or Foreign	_
	Funeral Director		215-42-8612	1 ∑ M 2□F	61	Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Year)	Pen	nsylvania	
			Usual Residence of Decedent				1			A	ug. 18	3, 19	944		-
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation			•				10d. Inside City Limits	
	Mar.	tor	Maryland Cecil			E1kt	on							1 ☐ Yes 2X No	
	1the	Director	10e. Street and Number				10f. Z	p Code				10g. Ci	tizen of What C	Country?	_
	3a o		321 Fletchwood	Road			21	921			ļ	IInit.	ed Stat		
	death ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Dece	edent of H	ispanic Origi	in? (Speci	ifv Yes or N		14. Race - Am		-
10	fter of riter	Ē	1 ☐ Never Married 2 ☐ Marrie	Armed For	^{ces?} 1962	2-	If Yes, sp	ecify Cuba	in, Mexican,	Puèrto Ri	can, etc.)		Black, Wh		
93	ors a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give	1065	5	1 🗌 Yes	2X No	Specify:				Specify:	White	
9	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-1 show fre Medical Evertifier must be muilled at	Completed	15. Decedent's	Education		16a. Dece	dent's Usi	ial Dccup	ation			16b. K	(ind of Busines	s/Industry	-
215	hin 7 nn "r Med	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	use retired	during most (I)	or working	7				
217	d wit	om	12	30 	101 017	Assemi	oly 1	ine	forema	an		Au	tomotiv	e	
b	Hygie other	Bec	17. Father's Name (First, Middle, La	ast)					18. Mother	s Name (First, Middle	, Maider	Sumame)		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show amy injury or other treumatic event, the Medical Evaning must be notified at DRG.	ToB	Harry Clement G	riffith,	Sr.				Kath	ierin	e Hen	ders	on		
ary	should I		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Addres	s (Street	and Number	or Rural F	Route Numb	er, City	or Town, State,	Zip Code)	_
	1 and 2 Health a tem 27 is		Katherine Way/Dau	ighter		422 A	Abiga	il R	oad,P1	ant	City,	FL 3:	3563		
Baltimore,	f Hei f Hei item othe		20a. Method of Disposition		20b. P	lace of Dispo	osition (Na	me of	2)	Dat	te	20c. L	ocation - City o	r Town, State	_
9	Pages nent of h ant: if ite ary or of		1 Surial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		State No:	emetery, crer	st Me	ethod	ist No	ovemb	8855 ²⁶	Nor	th Fact	Maryland	
	permit. Pag Department Important: I eny Injury o		21. Signature of Fineral Service Li			1.6	111616	rv	3				1 Home	, rial y Land	
Ba	permit. Departr Importe eny inju		1100										East,MD	21001	
			23a. Part1. Enter the disease, or c	omnlications that ca	used the death								ast, m	Approximate	
			shock, or heart failure. List or	altropo course on or	oh lino									Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	26/0V	ascu	Kar	1100	ide	nT	Hemo	71.1	ayıc	~ 6 hour	S
	/Medical Examiner		roduling in double	Due to (or as a consequ	uence of):			ten				9	~ 75.0	
		_	Sequentially list conditions,	b	36 MI	141	179	per	ren	3101	7			~ 25 99	-
	Si ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):		1							
	and tran	cam	that initiated events resulting in death) Last	c											
30,	e ex cian a urial	E E	resorting in doutin) East	Due to (or as a consequ	Jence oi):									
68760,	ficate be executed physician and s the burial-transit	edicai		d											_
_	ortific ing p		IF FEMALE:											1	
Вох	death certifu attending I	an/l	23b. Was decedent pregnant	23c. If yes, outo 1 ☐ Live bi	come of pregnanth 2 Fetal	ncy Ideath 3[∃Ectopic r	regnancy					23d. Date of de		
Щ.	dea od fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de		Dther (s						Month	Day Year	
P.O.	at the by th	Physician/M	9 Unknown												_
	Physician: The law requires that the death certif r this certificate has been signed by the attending ral director, page 2 should be detached for use a	by F	Part II. Dther significant condition									tobacco i	use contribute t	to the cause of death?	
Ď	w require been sign	ed	ALCOHOLA	BUSE,	OLD	CERE	3/200	ASCU	LAR A	CLIPEN	10	Yes 2	□No 3□P	robably 4 Onknown	
of Vital Records,	s bee	Completed	Right hemin	areris							24a. Was	an		utopsy findings available	_
Re	he lav e has age 2	mo	- · · · · · · · · · · · · · · · · · · ·			-						ormed?	death?	completion of cause of	
<u>a</u>	sician: The certificate harector, page	ပိ	25. Was case referred to medical						00 Pl	(P) - 11 (1 Yes	2 No	1 Ye	s 2 No	_
5	sicia cert irect	8	examiner?	Hospital:		ER/Outpatier		Othe	ar.		Check only				-
of	Phys rat di	- To	27. Manner of Death	28a. Date o		28b. Time of		UA	4 LINUIS		d. Describe		6 □Dther (Spe	ecify)	_
no	ding I h. After funer	tion	1. ■Natural 5 □ Pending	(Month	n, Day Year)	Injury	м	28c. Injury Work	k? Yes 2 ⊡ No		a. 20001120	.,,,,,,	,, 00001100		
S	deat deat ctor: / the	ica	3 Suicide 6 ☐ Could no	t be 200 Bloom	of Injury - At ho	me farm str					f Location /	Stroot ar	nd Number or F	lural Route Number.	_
Division	i or Attendater deatl	Certification:	4 Homicide determin	ea buildin	g, etc. (Specif)	/)	JOI, INCIO	y, onice		20	City or To			and Home Humber,	
-	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		20a Cartifier	Physician T- **	hoot of l	udodae de d	h ===	4 -4 45 - 4			d dec 4 - 4				_
	To the Hospital within 24 hours and the Funeral completely filled	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the kaminer: On the ba	sis of examinal	wieage, death tion and/or in	n occurred vestigation	at the time, in my of	ie, date and pinion, death	place, and occurred	a due to the at the time,	date and) and manner a d place, and du	s stated. e to the cause(s)	
	the the	Med	29b. Signature and title of certifier	and mann	er stated.		20	c. License	number			204 Da	te signed (Mon	th Day Year)	_
	To To cor		AAA LILIE OF CERTIFIER	SOM/_	()	n				77			_	23, 2005	bo
			- Willelia	C-1105	VM	U		003	592:	43		11000	-11/05.1	23, 2005	_
	LIVA		30. Name and address of person w	ho completed cause	of dean (Item	23a) (Type,	Print)	~ ~	10-						
L	TIVA		215 North Street				MI	16	1421						_
	Sta Registr		31. Date filed (Month, Day, Year)	32, Re	gistrar's Signa	ture									

		1- For State of Maryland / Dep Registrar Ce	eartment of Health and Mental ertificate of Death	Il Hygiene 05 40210
Physic /Medi		Decedent's Name (First, Middle, Last) RICHARD L. GREEN, SR.	2. Date Mon NOV	
Exami		4a. Facility Name (If not institution, give street and number) 7214 DUSTIN DR.	4b. City, Town, or Location of Death SHARPSBURG	4c. County of Death WASHINGTON
Funeral Director		5. Social Security Number 578-30-2933 6. Sex 10 M 2 F 7. Age (In yrs. last birthday 92 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. AUG	e of Birth (State or Foreign Country) 9. Birthplace (State or Foreign Country) VA
Maryland 9-f show	tor	MD WASHINGTON SHARPSE		10d. Inside City Limits 1 ☐ Yes 2 No
th with the 23s or 28 let be not	ai Director	10e. Street and Number 7214 DUSTIN DR.	10f. Zip Code 21782	10g. Citizen of What Country? USA
and 2 should be filed within 72 hours after death with the Maryland 1 health and Mental Hyglene. I Health and Mental Hyglene. Item 27 Is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Maxical Examiner must be nutified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give/Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 📈 No Specify:	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
d within 72 highen.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) ENTER	16b. Kind of Business/Industry CONSTRUCTION
cal y call of LE	To Be C	17. Father's Name (First, Middle, Last) DANRIDGE M. GREEN	18. Mother's Name (First, A EVA PRICE	Middle, Maiden Sumarne)
			ing Address (Street and Number or Rural Route I 4 DUSTIN DR., SHAR: osition (Name of Date	
t. Page rtment o rtent: If		1 ABurial 2 Cremation 3 Removal from State LAYTONS	windary or other place) VILLE CEM. 12/2/05 12. Name and Address of Facility	
Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	HILTON FUNERAL HOM P.O. BOX 86, BARNE; ster the mode of dying, such as cardiac or respira	SVILLE, MD 20838
that the death certificate be ended by the attending physicien detached for use as the burial	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
w requires that been signed b	by	Part II. Other significant conditions contributing to death but not resulting in the to	inderlying cause given in Part I. 23e.	e. Did tobacco use contribute to the cause of death? 1) Yes 2 \(\subseteq \text{No} \) 3 \(\supseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)
sicion: The law restricted has be rector, page 2 sh	e Completed	25. Was one referred to marked	1 🗆	a. Was an autopsy performed? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
d S ×	To B	25. Was case referred to medical examiner? 1		Residence 6 Other (Specify)
To the Hospitel or Attending Ph Within 24 hours atterdeath. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	City	ation (Street and Number or Rural Route Number, or Town, State)
o the Hosi ithin 24 ho o the Fund ompletely f	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to extract the strategy of th	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
F 3 F 8		30. Name and address of person who completed sause of death (Item 23a) (Type)	D26523	Noverya 28,2005
Sta Regist		31. Date filed (Month, Day, Year) 3 0 2 005	Sperke HXGER	100 × 10

			For State Registrar 1. Decedent's Name (First, Middle, Last.	State of Ma		Depa	rtme		ealth and	Mental Hyo	jiene Rog. No	005	4 0 2	4 Dooth
//	ysicia Medic amin	ai	Alberta Marion Co 4a. Facility Name (If not institution, give	Ison Gray	imore	9	4b. City	12:	Location of Dea	Novembe	Day 2 4c.	Year 200 County of Dea	5 1:41 th	A M
Dire			5. Social Security Number 6. Sec. 219-05-1869 1C Usual Residence of Decedent	7. Ag	e (In yrs. last t	Yrs.	Months		If Under 24 Hr Hours Mir	n. (Month, Day	Year)		thplace (State ountry) th Carc	olina
h the Marylar or 28a-f ehow	a netified at	Irector	10a. State 10b. County Maryland Baltimore 10e. Street and Number	City	Baltir			ip Code			10g. Cit	izen of What Co		ity Limits
5-0036 72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow	niner roust be	Funeral Directo	1814 East Oliver St 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N					panic Origin? (, Mexican, Pue	Specify Yes or No- into Rican, etc.)		USA 14. Race - Ame Black, Whit	e, etc.	
21215-0036 d within 72 hours aff giene. er then "natural", or	Medical Exa	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			Sa Deced	ant's ! le	21 No ual Occupat ork done du use retired)		orking	16b. K	Specify: Bla ind of Business		
laryland 2127 2 should be filed within and Mental Hygiene. Is merked other then	c event, the	Be	17. Father's Name (First, Middle, Last)	•	H	lome	make			ame (First, Middle,	_	Domesti Sumame)	C	
ore, Nos 1 and of Health	r other traumati	ဥ	Lee 19a. Informant's Name/Relationship (Ty Arthur D. Gray/son 20a. Method of Disposition 1 ③ Burial 2 □ Cremation 3 □ F			96. Mailing 3921	Fall	staff	Road -	Sell Rural Route Numbe Baltimore Date	e, M		5	
Baltimore, permit. Pages 1 ar Department of Hea Important: if Itam	any Injury o		4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licens		I	Ridg	e Co	emete ind Address	ry 11/ of Facility12	30/2005 13 Jersey L CHAPEL	Roa	imore, ad - Sal	Marylan lisbury, 218	MD
Physic /Med	lical		23a. Part1. Enter the disease, or a mushock, if heart failure. List only in mediate Cause (Final disease or condition resulting in death)	Metas	the death. Do	o not ente	r the mo	de of dying		the state of the s			Approxima Interval Bel Onset and	te tween
icate be executed XIII	ie burial-transit	cal Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last		a consequenc									
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ON O ling Pt After th	funeral	T0 B	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	lospital: 1 ⊠ Inpatie 28a. Date of Inju (Month, Da	ry 28b y Year)	Time of Injury	М	OA Other 28c. Injury a Work? 1 Ye	4 ☐ Nursing	Home 5 Resid	ence		cify)	
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To the Hospital within 24 hours a To the Funeral	completel	Medical	one)	ner: On the basis of and manner sta	examination a sted.	and/or inv	estigatio	n, in my opi	nion, death occ	curred at the time, d	ate and	I place, and due	to the cause(s	_
31 12 12	Sta	e	29b. Signature and title of certifier Agarwal 30. Name and address of person who con NIKHIL AGAR WAS 31. Date filed (Month, Day, Year)	ompleted cause of d	eath (Item 23a	los al	Print)	of ba	Stimos	e 2401 h	16e	l velore	AV. M.D	1-212
Re	gistra		31. Date filed (Month, Day, Year) NOV 2 9 20	105	K	A	ALB!	j						

DHMH 17 Rev 1/2001

CAKEL ALBERTA M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHN Ε. HARTWELL 19,2005 2:40P Nov. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Cheverly Prince George County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | May 29, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Wash. D.C. 1**★** M 2 🗆 F 73 577-42-0339 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington, D.C. Wash. DC 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20019 4308 Jay Street, NE 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify:Black 1 ☐ Yes 2 No Specify: 3 to Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Postal Worker

20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Mem. Cemetery

Post Office

20c. Location - City or Town, State

Suitland, MD

18. Mother's Name (First, Middle, Maiden Sumame)

Mary D. Armstrong

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15308 Johnstone Lane Bowie, MD 20721

11/28/2005

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.

nt: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-1 ehow ry or other traumatic event. The Medical Examinar must be notified at nore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

William L. Hartwell 19a. Informant's Name/Relationship (Type, Print)

Larry E. Hartwell/Son

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

11

20a. Method of Disposition

College (1-4or 5+)

Director

Funeral

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Completed

Be

Funeral

Director

Pag Int:		4 □Donation 5 □Other (Specify,)	TTHICO.	m ran. Cale	Lery 11/2	.O/ ZC	05 50	illiani, in	,
permit. Pag Department Important: eny Injury		21. Signature of Funeral Service Licens	ell_			Address of Facility Consylvania Ave				Inc.
		23a. Fart1. Enter the disease, or comp	fications that caused the cause on each fine	ne death.	Do not enter the mode	of dying, such as cardi	ac or re	spiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Sepsis							36 hours
/Medical Examiner		Todaking in dealing	Due to (or as a Chronic		iratory Fa	ilure				6 months
	ē	Sequentially list conditions, if any, leading to immediate	Due to (ur as a	consequer	ice of).					
uted d ansit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Encepha	lopat	hy					6 months
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cords, P.O w requires that the been signed by th should be detache	2	Part II. Other significant conditions of Seizure Disor		not resulti	ng in the underlying ca	use given in Part I.				to the cause of death? Probably 4 区Unknown
Rec The law ate has b	Completed							24a. Was an autopsy performed	24b. Were prior to death?	autopsy findings available completion of cause of es 2 \sum No
of Vita Physician: ribis certific	Be	25. Was case referred to medical examiner?	Hospital:			Other		theck only one		
Phys this ral dii	£	1 ☐ Yes 2 2 No 27. Manner of Death	1 & Inpatient		VOutpatient 3☐ DO Bb. Time of 2			5 Residence Describe how	e 6 □Other (Sp	necify)
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Divisi To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of liner: On the basis of a and manner state	examination	edge, death occurred and/or investigation,	at the time, date and pla in my opinion, death oc	ce, and	due to the caus at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	Me	29b. Signature and little of certifier	eury		299) (6273)	~	D 29d.	Date signed (Mo.	nth, Day, Year)
0 (1)		30. Name and address of person who o	completed cause of dea	ath (Item 2	3a) (Type, Print)					
		Revathy Murphy.M	1.D. 6330 L	andov	er Road Cl	neverly, MD	20	785		
St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 8 200	32 Registrar	's Signatur						
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	Funeral					ast birthday)	If Under	1 Year	If Under 24	Hrs. 8. C	Date of Birth Month, Day,		9. Birt	hplace (State or Foreign
	Director		122-03-2099	10XM 2□F	87	Yrs.	Months	Days	Hours		Month, Day, ril 1(Co	untry) York
	pu >		Usual Residence of Decedent 10a, State 10b, County		10- 00	-							0 1 11011	
	shov	<u> </u>		C		, Town or Lo								10d. Inside City Limits
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	with t	ក					10f. Zlp	Code	22772		1		n of What Co	untry?
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98	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or items 23e or 28e-f show event, tre Medical Exerting raist be notified at	y Funeral Director	1 ☐ Never Married 2 ☑ Married	Armed Forces 1 X Yes 2 If Yes, Give	?] No		f Yes, spec		spanic Origin n, Mexican, P	Puerto Ricai	n, etc.)		Black, White	e, etc.
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7-	"nat	lete	15. Decedent's E (Specify only highest gi	ducation rade completed)		16a. Deced		k done d	uring most of	f working		16b. Kind	of Business/	ndustry
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p	Hygin other ant, I	BeC	17. Father's Name (First, Middle, Las	t)					18. Mother's	Name (Fire	st, Middle, N			
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Ba	permit. Depertrimporte any inju		6512 N.W. Crain Hwy., Bowie, M											d 20715
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	/Medical Examiner		Todaking in doubly	Due to (or a	a consequ	ience of):								
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o.	0 0 0	Physician/M	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of de	ath 5∟	Other (spe	cify)					77.07.11	Day Tour
<u>α</u>	de de		Part II. Other significant conditions	contributing to death	but not resu	Iting in the un	derlying ca	use giver	n in Part I.	2	3e. Did tob	acco use	contribute to	the cause of death?
rds	quires n slgn uld be	d by	Demen	hi							1 🗆 Yes	s 2 N	No 3□Pro	bably 4 Munknown
00	s been s	olete								2	4a. Was an	2	4b. Were aut	opsy findings available
Vital Records,	The law ate hes b page 2 st	Completed		-						-	autopsy	ed?	prior to co death?	empletion of cause of
ita	ician: Certifical	Bec	25. Was case referred to medical						26. Place of			No No	1 🗆 Yes	2 No
of <	S S	To 8	examiner? 1 ☐ Yes 2 X No	Hospital: La Inpati	ient 2 🗆 E	R/Outpatient	3 DOA	Other	~				Other (Speci	fy)
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	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Salc	29a. Certifier (Check only 2 Medical Example 1	hysician: To the best	of my know	rledge, death	occurred a	t the time	, date and pl	lace, and di	ue to the car	use(s) an	d manner as s	stated.
	To the H within 24 To the F complete	ledical		miner: On the basis of and manner st	tated.	on and/or inv				occurred at	the time, dat	te and pla	ice, and due t	o the cause(s)
	viti Con	Σ	29b. Signature and title of certifier	0	7:01		29c.	License	number	<i>(</i>)	29	d. Date s	igned (Month,	Day, Year)
. /	20/11		30. Name and address of person who	completed acres	ے ہور	220) (7:	leint's	ノ ヿ ・	- 000		0	11	- 18	2071.
1	20/10	\	1930. Name and address of person who	CALC		23a) (Type, F	2 X	5	1, 15	M	Dec	-10	M 12	2071.
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-	Examir	er	Prince George'	-		· · ·		everl		OI DOGUI						_
	Formula		5. Social Security Number	6. Sex		s. last birthday		r 1 Year	,	r 24 Hrs.	8. Date of B		THEE		orge's	
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	deat	Funeral	11. Marital Status	12. Was D	ecedent Ever in	U.S. 13	Was Dece			rigin? (Sp	ecify Yes or N Rican, etc.)		14. Race	- Amer	ican Indian,	
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7	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or theme 23a or 28a-1 show ont, the Medical Examiner must be notified at	Completed	12TH			CONST	RUCTI	ON W	ORKE	R		PF	RIVAT	E		
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Maryland	uld b Ment wrke rrke rrke	To	TERRANCE HAYNES	S					JOY	WILL:	IAMS					
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	and a salth 27 i		TERRANCE HAYNES / FATHER 708 DESHON CREEK DR. LATHONIA, GA 30058													
Sre	of He		20a. Method of Disposition	2 🗆 🖰 🖰 1 (. Place of Disp cemetery, cre	osition (Nar	me of other plac	:ө)		Date	20c. L	ocation - 0	City or T	own, State	
Ĕ	Pagent nent in our in o		XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			SURREC				29 N	OV 2005	CI	LINTO	N. 1	TD.	
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	Physician		Immediate Cause (Final				HOT							-	Onset an	
10	/Medical		disease or condition resulting in death)	a	to (or as a cons		HOI	000	5000	7				-		
41	Examiner				(0, 00 00 00 00	- 420.1100 017.										
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Ď	death a atte d for	드	in the past 12 months? 1 ☐ Yes 2 ☐ No		re birth 2 □ Fe egnant at time of		⊒Ectopic pi ⊒ Other (sp						Mon	th	Day	Year
0	the oy the	nys	9 Unknown	9□ ∪r	known											
O _	The law requires that the death certifi Ite has been signed by the attending I vage 2 should be detached for use as	by P	Part II. Other significant conditi	ions contributing to	o death but not re	esulting in the	underlying o	ause give	en in Part	1.	23e. Did	tobacco	use contri	bute to 1	the cause o	f death?
g	uires n sign										1 🗆	Yes 2	128(No :	3 🗆 Prol	bably 4 [_Unknowi
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_	ite led	O			STREE	. [9	I L.,	1111	- 11 8	/	110

To the Hospital or Atterwithin 24 hours after des To the Funeral Directo completely filled in by the

ANA RUBIO, 31. Date filed (Month, Day, Year) State Registrar NOV 2 8 2005

29a. Certifier

29b. Signature and title of certifier

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 22, 2005

			1 - For State of Many State of Many State		artment of Health and rtificate of Death	Mental Hygier	LUUJ '	+0215			
	Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death			
	Physici: /Medic		Mary Estelle Hall				21 2005	5:21 P ^M			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat	th	4c. County of Death				
			Southern Maryland Hospit		Clinton			George's			
	Funeral		1□M 2□XE	n yrs. last birthday) 88 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Yea	Day, Year) Country)				
	Director		579-30-5860 Usual Residence of Decedent			July 6, 19	917 Was	sh., DC			
	yland 10W	Ì	10a. State 10b. County 10	Oc. City, Town or Lo	cation		10d. Inside City Limits				
	Mar Mar	į	Maryland Prince George's		Suitland			1∏Yes 2□No			
	th the	Director	10e. Street and Number		10f. Zip Code		Citizen of What Cour	ntry?			
	th will	aiD	2228 Houston Street		20746		United	States			
	dea man	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ Black, White,	can Indian,			
98	or it	Y.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No Specify:	,		31ack			
ë	within 72 hours after death with the Maryland ene. than "neturel", or itema 23a or 28a-f ehow the Madical Examiner must be notilled at	d by	3 Widowed 4 □ Divorced Year or Dates:			1.2	1				
쟌	n 72 "nai	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	nking 16b.	, Kind of Business/In	dustry			
12	withi than	E C	Elementary/Secondary (0-12) College (1-4or 5+)		Homemaker		Privat	te			
0	be filed stal Hygis of other	Be C	17. Father's Name (First, Middle, Last)	1	18. Mother's Na	me (First, Middle, Maid	len Sumame)				
<u>a</u> n	Mental Ked Ked	To B	Robert Patterson			Mary Mi	119				
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or itema 23a or 28a-f show aumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or R			Code)			
Σ	and 2 lelth a		John Bell / Son	222	8 Houston St., S	uitland, M	20746				
Baltimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: if item 27 te marked eny injury or other traumatic es		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place)	Date 20c.	Location - City or To	own, State			
Ĕ	Pag ment ant: i			Maryland	Veterans Cem. 11	/30/05	Cheltenh	nam, MD			
ant m	Depart Import Import Infort Infort		21. Signative of Funeral Service Licensee	22	2. Name and Address of Facility S	tewart Fune	eral Home				
	Q = 9 d		John Jeward T		4001 Benning Rd		sh., DC 20	0019			
			23a. Part1 Enter the disease, or complications that caused the shock of heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death			
,	Physician		Immediate Cause (Final disease or condition resulting in death)	10 No	-SFIRATORY	HOWN		Oriset and Death			
	/Medical Examiner		Due to (or as a c	consequence of):	ERIADOLY	(
		5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	SHUHUY	0-19/1051	J					
	uted 1 Insit	E I	Cause (Disease of injury	7							
ć	execting and ital-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a c	on sequence of):		•					
8760,	cate be executed physicien and the burial-transit	dicai	d								
9		led	IF FEMALE.								
Вох	eath certif attending for use as	an	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2		Ectopic pregnancy		23d. Date of delive	*			
	e death the atte	SICI	in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 9 □ Unknown		Other (specify)		Month	Day Year			
P.O.	that the de ted by the a detached t	Physician/Me	Partil. Other significant conditions contributing to death but r	not reculting in the u	nderhing source given in Red I	22a Did tabasa	o use contribute to t	be source of death?			
ds,	S 50	Completed by	AMENIOSCULADITIC CA	A NICOLA	SUMO DIS	4 1 Yes		pably 4 \(\sum \text{Unknown}\)			
Ö	> 0 0	etec	146,000	(2100)	source, so	OC.					
Rec	has has	du				24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of			
a	tician: Th certificete rector, pag		25. Was case referred to medical			1 ☐ Yes 2 🔣	No 1 ☐ Yes	2 No			
₹	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatier	Dthoc	ath <i>Check only one</i> Home 5 Residence	6 DOther (C	4.1			
Division of Vital Records,			27. Manner of Death 28a. Date of Injury			28d. Describe how in		9)			
Ö	Attending Phir death.	atlo	1 Matural 5 ☐ Pending (Month, Day Y 2 ☐ Accident investigation	ea <i>r)</i> Injury	M 1 Yes 2 No						
<u>×i</u>	or Attend after death Director: A	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, str	reet, factory, office	28f. Location (Street City or Town, St.	and Number or Run	al Route Number,			
	ital or rs afte al Dir led in	Ce									
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	Check only Check	camination and/or in	h accurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(c) and manner as s and place, and due t	tated. o the cause(s)			
	To the within 2. To the R complete	Med	one) and manner stated	d.	29c. License number						
	7 × 10 00 00 00 00 00 00 00 00 00 00 00 00		Sold of the sold o		D-10016		Date signed (Month,				
Λ	97)		7 VV	th (ltn= 00-) 7	18373		CME/C/				
VL.	(3)		30. Name and address of person who completed cause of deat	11 (Item 23a) (Type,	D LING 191	NEN WHA	ARIF. 1.	21, 2005" U 20602			
	Sta	ite		Signature.	- Joing con	inc with	10/04	1 2000			
	Registr		NOV 2 8 2005 Keepin	N Aus	de la companya della companya della companya de la companya della						

Josie Jones 05-7847 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#23 PI, a b.27, 28a-f, perME, 0851, 1/25/06 II

State of Maryland / Department of Health and Mental Hygiene

J -	,		1 - For State Registrar	State of Ivial		tificate of D		•	Reg 2N. 005	40216
	Physicia	an	1. Decedent's Name (First, Middle, La	ast)				2. Date of De Month	Day Year	3. Time of Death
45	/Medic		JOSIE		JONES			Novemb	er 21, 2005	
	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or I	Location of Deat	h	4c. County of Dea	
N _j ge	F	坐表	Southern Marylan 5. Social Security Number 6.		'In yrs. last birthday)	Clinton If Under 1 Year	If Under 24 Hrs	8. Date of Bir		George's
	Funeral Director		410-40-6284	1□M 2⊠F 82		Months Days	Hours Min.	(Month, Da Decem	ber 23 Mis	thplace (State or Foreign buntry) SISSIPPI
	and		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d. Inside City Limits
	Manyl 1 eho	ō	MD Prince (Forestv					ty∏Yes 2☐No
	r 28a-	rec	10e. Street and Number	Beorge 5	101050	10f. Zip Code			10g. Citizen of What Co	ountry?
	23a o 23a o	Funeral Director	6102 Cedar Post	Drive		20747			U.S.A.	
	ems ems	ıner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of His f Yes, specify Cuban	spanic Origin? (S	Specify Yes or No	14. Race - Ame Black, Whit	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any figury or other traumatic event, I're Medical Examinational Le notified at Once.	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2⊠ No		, , , , , , , , , , , , , , , , , , , ,	Specify:	Black
5	"natu	Completed	15. Decedent's E (Specify only highest g		16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion u <i>ring most of wo</i>	rking	16b. Kind of Business	/Industry
2	withir ene. then	d L	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		d Process			Private	
ס	ntal Hygie od other t	Be Co	17. Father's Name (First, Middle, Las	t)	100			me (First, Middle,	Maiden Sumame)	
Maryland	Aenta Aenta rked rtc ev	To B	Willie Evans				Inez V	White		
ary	and h		19a. Informant's Name/Relationship						er, City or Town, State, .	
≥ √	and ealth m 27		Beatrice Jones/	Daughter				-	ille,Maryla	
Baltimore,	iges 1 if ite or ot	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cemetery, crei	sition (Name of natory or other place	I	Date	20c. Location - City or	
┋	it. Pa intmer intent njury		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	-		Cemetery Name and Address			Memphis, T	
Ba	permi Depa Impo any ir		21. Signature of Furneral Service Lice	1-11					KINS FUNERA ER, MARYLAN	
,10	7		23a. Part1. Enter the disease, or cor shock, or hear failure. List ont	nplications that caused th						Approximate
	Physician		Immediate Cause (Final disease or condition	one cause on each line.	Intracran	1al Hellorma	ige	1	The state of the s	Interval Between Onset and Death
£	/Medical		resulting in death)	Due to (or as a	consequence of):			rough		
	Examiner	_	Sequentially list conditions,	D	ntal cortica	1 contusion				
	ped list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	rificate be executed ng physician and as the burial-transit	xan	Cause (Disease or infury that initiated events resulting in death) Last	c Due to (or as a c	consequence of):					
68760,	e be e	cal		d.						
9	tificat ng phy as th	ledi						1,		
Š	ith cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy			23d. Date of de	
P.O. Box	the at	Physician/Medical	in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	4 Pregnant at tir 9 Unknown		Other (specify)			Month	Day Year
	that the by detac	Ph	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giver	n in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	d by	Cancer		•	,,,		10	A. A	robably 4 Unknown
ဝ္ပ	s bee	Completed				****		24a. Was	an 24b. Were au	utopsy findings available
	The fa	E		*					osy prior to d ath? 2 No 1 ses	completion of cause of
Division of Vital	sian: artifica ctor. p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath Check only o		20110
<u>></u>	hysic this ce il dire	ို	1 X Yes 2 □ No	Hospital: 1 Inpatient		it 3□ DOA Other	r: 4 🗌 Nursing F	lome 5 ☐ Resi	dence 6 Other (Spe	cify)
Ĕ	ling P	o E	27. Manner of Death 1	28a. Date of Injury (Month, Day)		Work	at ?	28d. Describe	now injury occurred	
<u>s</u>	l or Attending after death. Director: After in by the fune	ficat	2 Accident Investigation 3 Suicide 6 Could not	De 290 Place of laive	3:00 P		es 2 No	Subject f	Street and Number or Bi	ural Route Number
<u>></u>	after after Dire	Certification:	4 Homicide determine	building, etc. Hane	(Specify)	ooi, radiory, direc		City or Tox	wn, State 6102 Ced	ar Post
	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1□ Certifying F	hysician: To the best of	my knowledge, deat	occurred at the time	e, date and place	Forestvill a, and due to the	cause(s) and manner as	s stated.
	- (4 - 0	Medical	(Check only 2 N Medical Exa	miner: On the basis of e and manner state	xamination and/or in	vestigation, in my opi	inion, death occu	urred at the time,	date and place, and due	e to the cause(s)
	To the complex	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mont	
	1		Leake	(NO)		0.C.	M.E.		November 23	3, 2005
2	(20)		30. Name and address of person who				Street	, Baltim	ore, Maryla	nd 21201
	Sta	ite	31. Date filed Month, Day, Year) NOV 2 9 200	Registrar'	s Signature			,	, , , , , ,	
	Registr	ar	140 6 8 3 500	Blain	K for	K.				
DH	MH 17 Rev 1/2	001			The same of the sa	111				

ORIGINAL

			For	State of Maryla		artment of He		•	_	le.
			1 - State Registrar	,		rtificate of D			leg. No.	40217
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	/Medic	al	Troy Lamont Ja 4a. Facility Name (If not institution, give			4b. City, Town, or L	anation of Dooth	11		05 8:50 P M
	Examin	er	7805 Marwood Driv			Clinton			4c. County of	ice Georges
Ī	Funeral		5. Social Security Number 6. Sec	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		188-54-7573 Usual Residence of Decedent]M 2□F 37	Yrs.		THE STATE OF THE S	11-03-	68	PA
	yland yland		10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	Director	MD Prince Ge	orges C	linton					1 X Yes 2 No
	with th		10e. Street and Number			10f. Zip Code		1	l0g. Citizen of Wh	at Country?
	leath y	Funeral	7805 Marwood Driv	12. Was Decedent Ever in	US 13	20735	nanio Origin? (Soc	wifu Vos or No	US 14 Base	American Indian,
٥	after d	Fun	1 XNever Married 2 Married	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give		Was Decedent of His If Yes, specify Cuban		Rican, etc.)		White, etc.
200	hours after death with the Maryland tural', or items 23a or 28a-1 show al Exartinat must be multiped at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1987	7-94				Specify:	Black
212-003p	within 72 hours after death with the Marylar ene. then "natural", or items 23a or 28a-1 show the Medical Exercines must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of worki	ng	16b. Kind of Busin	ness/Industry
7 7	d with giene. sr than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		an Resourc			Federal	Gov't
9	be filed wil tal Hygien d other th	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,		
Maryland	0 6 0 0	၉	Albert Jackson, S				Sheryl			
Z Z	01 00 00		19a. Informant's Name/Relationship (Ty Sheryl E. Jackson,	_		ng Address <i>(Str</i> eet an Marwood Dr				ate, Zip Code)
e,	_ ~ = +		20a. Method of Disposition	20b.	Place of Dispo	esition (Name of matory or other place)	, D		20c. Location - Ci	ty or Town, State
Ē	Page ment ant: if ury or		1 🎇 Burial 2 □ Cremation 3 □ R `4 □ Donation 5 □ Other (Specify)			National	11-30	-05	Cheltenh	am. MD
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service License	4-11		2. Name and Address	of Facility Str	ickland	Funeral	Services
	452 4 4		23a. Part1. Enter the disease, or compli	cations that caused the de		500 Allent				MD 20748 Approximate
	Physician		Immediate Cause (Final	ie cause on each line.			3001 as cardiac o	i iespiiatory am	63t,	Interval Between Onset and Death
	/Medical	Pr. 13	disease or condition resulting in death)	. <u>Carcenoma</u> Due to (or as a conse		.g				
	Examiner	_	Sequentially list conditions, if any, leading to immediate)						
	nsit	Examiner	Cause (Disease or injury	Due to (or as a conse	equence of):					
ב ב	be executed ician and burial-transit	Exai	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
g/60,	ate be executed hysician and the burial-transit	Ical		l						
ŏ X O	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of preg	nanov					
20	death of atten	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	- /
j.	y the	hysl	9 Unknown	9□ Unknown						
ras, r	law requires that the de as been signed by the i 2 should be detached	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause given	in Part I.			ute to the cause of death?
000	requi	eted								☐ Probably 4 X Unknown
Œ.	has has	Completed						24a. Was a autops perforr	y pric	re autopsy findings available or to completion of cause of ath?
VItal	ician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Death			Yes 2XNo
> 10	8 5	To B	1 198 2 X 90		☐ ER/Outpatier	O++			ence 6 Other	(Specify)
	fer fer	lon:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?		8d. Describe ho	ow injury occurred	
VISION	al or Attending s efter death. al Director; Afte ad in by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, str		s 2 No	8f. Location (St	reet and Number	or Rural Route Number,
2	P effect	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	city)	,,,		City or Towr	i, State)	
	To the Hospital of within 24 hours end the Funeral Completely filled in	edical (29a. Certifier 1 Certifying Phys	ician: To the best of my kiner: On the basis of examin	nowledge, death	occurred at the time	, date and place, a	and due to the ca	ause(s) and mann	er as stated.
	To the hwithin 24	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License r			9d. Date signed (f	
	To To		Mart O.	meetzn	_	D2374			11-28-	
)	(M)		30 Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type,	Print)			11 -20-	
	-(//		Martin D. Weltz 7	525 Greenway		Drive, G	réenbelt,	, MD 20	770	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2005	3. Registrar's Sign	nature	K				
		÷.	110 4 4 3 2003	LEGIC A						

			For State Registrar	State of Maryland /		tment of		nd Men		ene (15	+0218
	Physicia	an	Decedent's Name (First, Middle, Last) Ronald Jones						ate of Death Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of C	Death	11	18 4c. Coun	05 ity of Death	110:34 A
I	Funeral Director		5. Southern Marylan 6. Security Number 6. Sev 579-90-9146	d HOSPITAL 7. Age (In yrs. last b		Clir If Under 1 Yea Months Day	r If Under 24	Hrs. 8. D	eate of Birth Month, Day, 2 26		9. Birth	eorges place (State or Foreign ntry) hington, D(
	TO.	2	Usual Residence of Decedent 10a. State 10b. County	10c. City, To								10d. Inside City Limits 1 X Yes 2 □ No
	with the N n or 28a-f be notifi	Direct	MD Prince 10e. Street and Number		tland	10f. Zip Code	1.6		10	g. Citizen o		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow amy injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	4260 Suitland Roa 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	ad, #203 12. Was Deceate Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	lf Y	207 as Decedent of Yes, specify Cu Yes 2⊠ N	Hispanic Origin ban, Mexican, F	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. R:	US ace - Americ lack, White, cify: B1a	etc.
Maryland 21215-0036	within 72 hourshe	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	(Give ki	O NOT use reti	e during most o red)	of working	1	6b. Kind of		ernment
land 2	uid be filed v Mental Hygie irked other i itic event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Roscoe Martin			ine Ope	18. Mother's	ly Ma	st, Middle, N	laiden Suma	ame)	
Mary	12 sho h and h 7 is ma trauma	•	19a. Informant's Name/Relationship (Ty		-		et and Number of d Road,					
Baltimore, I	Pages 1 and ent of Healt at: If Item 2 by or other		Francine T. Jones/ 20a. Method of Disposition 1Xi Burial 2 Cremation 3 GR 4 Donation 5 Other (Specify)	20b. Place cemer	of Dispositery, crema	tion (Name of atory or other p	/ace)	Date 1-26-	2	20c. Location		own, State
Baltii	permit. P Depertme Importar any injur		21. Signature of Funeral Service Licens	trickland	650	Name and Add	ress of Facility	Strickoad,	kland Camp S	Funer pring	al Ser	rvices
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Done cause on each line. a. Acquired To Due to (or as a consequence)								Approximate Interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence d.								
P.O. Box 68	The law requires that the death certifica ete hes been signed by the attending ph page 2 should be deteched for use as if	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnar Other (specify)	ncy			1	Date of delived	rery Day Year
	w requires that to be signed by should be determined.	ρ	Part II. Other significant conditions con	Facture - C	g in the und		given in Part I.			acco use co		the cause of death?
Division of Vital Records,	: The law rec cete hes bee , page 2 shor	Completed						_	24a. Was ar autops perform 1 ∐ Yes 2	n 24t y ned?	prior to co death? 1 \(\text{Yes} \)	opsy findings available ompletion of cause of
Vita	sicien certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/	Outpatient	3□ DOA ()ther		eck only one	-	has (Casa	4.1
ion of	To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: Affer this completely filled in by the funeral di	ation: To	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	1	o. Time of Injury	28c. In	4 🗀 14013	28d.	Describe ho			, <u>y)</u>
Divis	spital or Attenours efter des nerel Director filled in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, offic	е	28f.	Location (Sti City or Town	reet and Nui , State)	mber or Rur	al Route Number,
	Hospital 24 hours e Funerel letely filled	edicai		sician: To the best of my knowled nar: On the basis of examination and manner stated.								
	To the within 2. To the Complete	Me	29b. Signature and title of certifier	Da		29c. Lice	nse number		25	9d. Date sig	1	
0	Tin		30. Name and address of person who co	ompleted cause of death (Item 23)	a) (Type, P		3696 uthern N	Maryla	nd Hos	- F	23/0	2)
_			Dr. Durkin, Willi	am 7503 Surr	atts							
	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 8 2005	2. Registrar's Signature	her							

			1 - For State Registrar	State of M	aryland		artmen <i>tificati</i>			nd Me		giana ()	5 4	021	9
	AC 3		1. Decedent's Name (First, Middle, Las	st)		-,				2.	Date of Dea	ath		3. Time of I	Death
и	Physici /Medi		Hamı 1	West	Jo	Ohnson	1				Month //	Day 23	Year	0155	- м
	Examir		4a. Facility Name (I) not institution, give	street and number)				Town, or L	ocation of	Death	//	4c. Cour	nty of Death		
			Crastal Hospia	e at the	Lake		Sale	sbur	21			(1)	OMic	(,	
2	Funeral	-117	5. Social Security Number 6. S		ge (In yrs. la	ast birthday)	If Under	1 Year	f Under 2		Date of Birt	h		place (State or ntry)	Foreign
	Director		505-26 - 2969	X M 2□ F	95	Yrs.	Months	Days	Hours	Min.	(Month, Da)			ntry) :hDakot	
	p		Usual Residence of Decedent								·/	J10		LIDAKOL	.a
	nylar	_	10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. tnside City	
	e Ma	cto	Delaware Sussex			Delmar								1 XYes	2 🗌 No
	or 2	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cou	ntry?	
	72 hours after death with the Maryland natural', or items 23a or 28e-f ahow dical Examinar must be multied at	a	400 Holly Court	Apt. 412				199	940			US	SA		
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?			Was Deced	dent of Hisporty Cuban	panic Origi Mexican	in? (Specifi Puerto Ric	y Yes or No-		ace - Ameri lack, White,		
90	or it		1 Never Married 2 Married	1 ∐Yes 2 X If Yes, Give	No		I □ Yes		Specify:		,	Spec		ite	
21215-0036	ural!	d by	3 Widowed 4 Divorced	Year or Dates:								Орос	y. W1.		
Ϋ́	nat	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	dent's Usua kind of wor	al Occupati rk done du	ion iring most o	of working		16b. Kind of	Business/In	dustry	
12	within ene. than	ф	Elementary/Secondary (0-12)	College (1-4or	5+)										
7	filed why hygie of the right.		17. Father's Name (First, Middle, Last)			Re	pairm		10 Markad	I- No /F	Vand Advisorita	Maiden Suma	ctric	Motor	
and	d of	Be	Harry William Jo	hneon				'							
Ž	2 should be and Mental is marked a	2	19a. tnformant's Name/Relationship			405 14 11		(0)				Sunderl			
Maryland	h and 7 is r		Betty jeanne Joh	** *								r. City or Tow Delmar,			
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28e-f ahow or other traumatic event. The Medical Examiner must be multiled at		20a. Method of Disposition		20h Pla	ace of Dispo			ALC. 1	Date					
Baltimore,	Pages nent of I ant: If Its ary or o		1 Burial 2 Tremation 3 🗆		Cel	metery, cren	natory or o	ther place)	1			20c. Location	1 - City or 11	own, State	
븚	tmer tmer tent ijury		4 □ Donation 5 □ Other (Specify		Sal	isbur						Salis	bury,	MD	
Sal	permit. Page Department of Importent: If any njury or once.		21 Signature of Euneral Service Licen	see		H H	Name an	d Address ay Fi	of Facility.	1 Hom	e Prof	ession	al As	sociati	ion
	40240		Maria 7:	acources	CF.	SP' 5	OI Sn	OW H	ill Ro	d., S	alisbu	iry, MD	2180	4	
			23a. Part1. Enter the disease, or comp shock, or heart faiture. List only	one cause on each li	d the death. ine.	Do not ent	er the mode	e of dying,	such as ca	ardiac or re	spiratory ar	rest,		Approximate Interval Betw	reen
	Physician		tmmediate Cause (Finat disease or condition	a Chrom	v Ob	Sport	me	Pu	lim	K	18000	0		Size S	jain)
110	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):			()				-	
	LAMITIME		Sequentially list conditions,	b											
	p :	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):									
	and tran	cam	Cause (Disease or injury that initiated events resulting in death) Last	c											
30,	Sien a	E		Due to (or as	a conseque	ence or):									
8760,	cate be executed physicien and the burial-transit	dical		d											
9	eath certific ettending p	Me	tF FEMALE:												
Вох	death certifi e ettending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗌 Fetal o	death 3	Ectopic pre						ate of deliver	,	ваг
0.	the deay the eached t	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of dea	ath 5□	Other (spe	ecify)					north)	Day 16	70.1
<u>o.</u>	es that the death igned by the ette be detached for	Ph				nin de abo					00. 0:11				
Š,		þ	Part II. Other significant conditions of	ontributing to death b	out not resul	ting in the ur	nderlying ca	ause given	in Part I.	1	- 2			ne cause of de	
Vital Records,	w requir been s should	Completed								_	120	es 2 No	3 Prot	ably 4 Dur	iknown
ec	hes b	ple									24a. Was a		. Were auto	psy findings av	vailable
<u>~</u>	The I	ПО									perfor	med2 2X No	death? 1 ☐ Yes	200	300 0,
<u> </u>	icien: Th certilicate ector, pag	Be (25. Was case referred to medical examiner?					- 2	26. Place o	of Death (C	heck only of			7	
	Physicien: this certific ral director,	2	1 Yes No	Hospital: 1 Impatie	ent 2 🗆 E	R/Outpatien	t 3 DO	A Other:	4 🗆 Nurs	sing Home	5 🗌 Resid	ence 6 🗆 O	ther (Specif	v)	
o c			27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year)	28b. Time of Injury	21	8c. Injury a Work?	at	28d	Describe h	ow injury occu	urred		
<u>.</u>	Attending r death. ector: After by the fune	atte	2 Accident investigation		,,	,,	М		s 2 No	0					
Division	l or Attendation after death Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At hon		eet, factory	, office		281.	Location (S City or Tow	treet and Nun	nber or Rura	Route Number	er.
	To the Hospitel or Attenwithin 24 hours after deating to the Funeral Director: completely filled in by the	Certification:													
	uner uner		29a. Certifier (Check only Medical Exam	ysician: To the best liner: On the basis o	of my know	ledge, death	occurred a	at the time	, date and	place, and	due to the o	ause(s) and n	nanner as s	ated.	
	the F in 24 the F iplete	Medical	oney	and manner st	ated.	and or my				Jocuil ed a	ar une ume, C	are and place	, and due to	rife cause(s)	
	5 4 4 5 V	2	29b. Signature and title of certifier	10			29c	. License r				9d. Date sign			
•	100		THE!		IN	M		0	2.6	27	8	11-	23.	.05	
	10		30. Name and address of person who o	11 . 1	1 0	1 1	Print)	0		1	72			21802	
	V		Drewed E. Colle		Dester		me	P.C	0.0	1 Ka	133	So	454	1802 NO	
	Sta Registr	* 4	31. Date filed (Month, Day, Year)	005 32. Registr	ar's Signatu	Ire A	-						\bigcirc	,	

			1 - State of I	Maryland / Department of Health at Certificate of Death		2005 40220
	Physicia	e e	1. Decedent's Name (First, Middle, Last) Vesta Kinca	A	2. Date of Death Month	
	/Medic	al	4a. Facility Name (If not institution, give street and numb		Nov. 2	22, 2005 7:00a M
	Examin		Harford Memorial Hospital	Havre de Grad		Harford
	Funeral			Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours		9 Birthplace (State or Foreign
	Director		Usual Residence of Decedent	Trs.	March 10),1919 Maryland
	nryland show	_	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	the Ma	ecto	Maryland Cecil 10e. Street and Number	Rising Sun	10	1 ☐ Yes 2 🛣 No
	3a or	Funeral Director	560 Calvert Road	21911		g. Citizen of What Country?
	r death	nera	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13. Was Decedent of Hispanic Origi		14. Race - American Indian, Black, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinating the notified at 2008.		1XNever Married 2 _ Married 1 _ Yes 2x If Yes, Give 3 _ Widowed 4 _ Divorced Year or Date	□ No 1 □ Yes 2√□ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White
9	2 hou	Completed by	15. Decedent's Education	16a. Decedent's Usual Occupation	1	6b. Kind of Business/Industry
215	within 7	mple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4-	·		Self Employed
d 21	filed w Hygien other the	o Co	12 17. Father's Name (First, Middle, Last)	Hairdresser 18. Mother	s Name (First, Middle, Ma	Beautician aiden Sumame)
lan	uld be fental rked o	To Be	Charles Herman Kincaid		Jourdan	· · · · · · · · · · · · · · · · ·
Maryland 21215-0036	2 sho and h Is ma	0 9	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	or Rural Route Number,	
e,	1 and Health em 27		Leone Monscevitz/Sister 20a. Mathod of Disposition	20b. Place of Disposition (Name of		MD 21901 Oc. Location - City or Town, State
Baltimore,	Pages nent of I ent: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	te West Nottingham	ovember 25 C	Colora, Maryland
alti	permit. I Departm Importer any inju		21. Signatura Francial Service Licensee	Cemetery 22. Name and Address of Facility	2005 Crouch Fune	eral Home
m	9 9 E 5 9		Jehn Son	127 South Main St	treet, North	East, MD 21901
	ASC .		shock, or heart failure. List only one cause on eac Immediate Cause (Final	sed the death. Do not enter the mode of dying, such as contine.	ardiac or respiratory arres	st, Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	as a consequence of:	4	
	Examiner		Sequentially list conditions, b.	enoscleration Card	yo vaseu	lar
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a cons, quence of):	vevaseu	disease
Ć,	execut n and ial-trar	Examiner	that initiated events c.	as a consequence of):		
68760,	ficate be executed g physician and ts the burial-transit	edicai	d			
-	= 0 g		IF FEMALE: 23c. If yes, outco	no of programmy		
Вох	w requires that the death certif been signed by the attending should be detached for use a	by Physician/M	in the past 12 months?	t at time of death 3 ☐ Ectopic pregnancy t at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.0.	that the c ed by the detached	hysi	9 ☐ Unknown 9 ☐ Unknown			
Ś	res the		Part II. Other significant conditions contributing to deat	h but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
Sorc	v requires been sign should be	eted			1 Yes	
of Vital Record	e la has	ompieted			— 24a. Was an autopsy perioring	prior to completion of cause of death?
ital	ysicien: This contificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place o	1 ☐ Yes Q of Death (Check only one	Ø No
of V	Physicien: this certific ral director,	2	1 Yes 2 No Hospital: 1 Imp			nce 6 Other (Specify)
	ding h. After fune	tion	27. I no of Death 1 ratural 5 Pending 2 Accident investigation	njury 28b. Time of 28c. Injury at Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred
Division	or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farm, street, factory, office etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
ā	urs after rel Dire					
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director:	edicai	29a. Certifier 1 Certifying Physician: To the be (Check only one) 2 Medical Examiner: On the basi and manner	ist of my knowledge, death occurred at the time, date and s of examination and/or investigation, in my opinion, death stated.	place, and due to the cau occurred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
)			1 F Tum	D. Drot	661	1/22/04
	6		30. Name and wress of person who completed cause	of death (Item 23a) (Type, Print)	1 Stormer	An Grove MD
	Sta	ite	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	1 . Hay The	2/04/101/
	Regist	ar	NOV 2. 9 2005 See en	in the		4010.

Kincaid, Vesta

	1	For State Registrar	State of I	Marylar			of Health of Death		F	Reg. No.	05	40221
hysiciar /Medica		Decedent's Name (First, Middle Joyce		Ken	dall				2. Date of Dea Month	Day 24	Year 05	3. Time of Death
xamine		a. Facility Name (If not institution Oustal Hospice Social Security Number	at the Lake	٠	last birthday)	Salis	wn, or Location	of Death	P. Data of Riv	4	Dicom	ico
neral ector		227-74-3131 Jsual Residence of Decedent	1 M 2 M F	55	Yrs.		Days Hours	Min.	8. Date of Birt (Month, Da) June 30	, Year) 0,195	Co	hplace (State or Foreign buntry) hington, DC
ust be nutitied at		MD 10b. County Dorce			ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No
Den.	1	0e. Street and Number				10f. Zip Co				10g. Citiz	en of What Co	ountry?
	1	110 Pintail Co 1. Marital Status 1 Never Married ***Married**	12. Was Decede Armed Force	s?	J.S. 13.		613 t of Hispanic Or Cuban, Mexica	rigin? (Spe In, Puerto F	cify Yes or No- Rican, etc.)	1	USA 4. Race - Ame Black, White	
2	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date it's Education		16a. Dece	1 ☐ Yes 🏋	occupation				Specify: id of Business/	White
	-	(Specity only nigne: Elementary/Secondary (0-12)	college (1-40)	or 5+)	Nurse	DO NOT use i	done during mo: retired)	st of workir	ng	Nu	ırsing	
Q C	ם 1	7. Father's Name (First, Middle, Wilmouth Mack	Last)					joyce	(First, Middle, Freder	ick		
		19a. Informant's Name/Relations James S. Kenda 10a. Method of Disposition				Pintai	treet and Numb	, Cam		MD		
		1 XBurial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S	pecify)	te	cemetery, crei	natory or othe Bethel	Cem.	12-3-			ton, M	
any injury or other ODCS.		21. Signature of Funeral Service	ensee		22	Harde:	ddress of Facil Sty Fundigely A	eral venue	Home, H	olis	, MD 2	1401_
ian cal		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	sed the death line. DLO as a consec	V		f dying, such as		_		NT	Approximate Interval Between Onset and Death
the burial-transit	LAGILLIA	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	c	as a consec as a consec								
Monal Mark		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant	2 Feta	al death 3	Ectopic pregr				23	3d. Date of deli Month	very Day Year
2	\$	Part II. Other significant condition	ons contributing to death	n but not res	sulting in the u	nderlying caus	e given in Part	l.	23e. Did to		_	the cause of death?
Completed	-								24a. Was a autop: perfor 1 Yes	sy	24b. Were aur prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
	2 2	25. Was case referred to medical examiner? 1 Yes 2 Yo 27. Manner of Death 2 Natural 5 Pendin investig	Hospital: 1 Inpa		ER/Outpatier 28b. Time of Injury			ursing Hom	(Check only or ne 5 Resid 8d. Describe h	ence 6	ther (Spec	
od in by the funeral		3 Suicide 6 Could a determination	286. Place of	Injury - At h etc. (Speci	ome, farm, str fy)	eet, factory, of	fice	2	8f. Location (S City or Tow	treet and n, State)	Number or Ru	ral Route Number,
n (29a. Certifier 1 Certifyin (Check only Medical	ng Physician: To the be Examiner: On the basis and manner	of examina	owledge, death ation and/or in	n occurred at t vestigation, in	he time, date ar my opinion, dea	nd place, at ath occurre	nd due to the c d at the time, d	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
pletely filled		one)				70- 1				0.1.0		
	_	one) 29b. Signature and title of certifie	r			29C. L	cense number		2	9d. Date	signed (Month	M. 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗍 🖔 State
State
RegistrarAmended items #15 & 20c per Certificate of Deathper fh/wiches No. 12-1-05/dls 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07:05 AM William Joseph Kimmel Jr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number egional medical Center WICOMICO 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10XM 20 F Yrs. 213-01-0065 Director 3/3/1915 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1⊠Yes 2 No Directo Maryland Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1135 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Manufacturing company 12 Financial Officer 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fit I Health and Mental H tem 27 le marked oti William Joseph Kimmel Sr. Gladys A. Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie K. Houston/daughter 124 75th St., Unit 201, Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Memorial Gardens or other place) 1

Burial 2 □ Cremation 3 □ Removal from State Timonium, Lutherville, MD 4 ☐ Donation 5 ☐ Other (Specify) 12/5/05 22 Name and Address funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Dais 4. accomob CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CEREBRAL INFARCT Physician DAYS /Medical Due to (or as a consequence of): FIBRILLATION Examiner ATRIAL 245 PKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of) Physician/Medical ettending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, GASTROINTESTINAL 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No ŏ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred W, II ar Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aff To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46962 NOVEMBER 27,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL St. SALISBURY M.C. 21801 MD MAHMAUD SHIRAZI 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 9 2005 Registrar

ysicia		1 - State Registrar				tificate of	Death	and Mental	Reg. N	000	40223
		1. Decedent's Name (First, Middle,	Last)					2. Date of		ay Year	3. Time of Death
ysici: Viedic		Reginald Aller						Nover	ber 2	26 2005	
amin	er	4a. Facility Name (If not institution,				4b. City, Town,		of Death		c. County of Deatl	h
		Howard County Ge 5. Social Security Number		ital ige (In yrs. Ias	st birthday)	Columb If Under 1 Yea		24 Hrs. 8. Date o		loward	hplace (State or Fore
eral ctor		217-80-1334	1 XX M 2□ F	45	Yrs.	Months Day	Hours	Min. (Month	. <i>Day, Y</i> ea. 5/196(r) Co	hington, D
		Usual Residence of Decedent		12.5						/RaSi	
I I	2	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limi 1 ☐ Yes 2X
offfile	Director	Maryland Howard		E1	Lkridg	e 10f. Zip Code			10- 0	ini	
ad I	ă		1 D 1			,	21075		rog. C	itizen of What Co	untry?
the Medical Examiner must be notified at	Funeral	9015 Thames Mead	12. Was Deceden		. 13.			gin? (Specify Yes o	r No-	U.S.A. 14. Race - Ame	
aria I		Never Married 2 Marrie	Armed Forces od 1 Yes 24		i	Yes, specify Cu I⊟Yes 27Ox No)	Black, White	
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dica	Completed	15. Decedent's (Specify only highest			(Give	lent's Usual Occu kind of work don	during mos	t of working	16b.	Kind of Business/I	Industry
Ne Me	m d	Elementary/Secondary (0-12)	College (1-4o	r 5+)		OO NOT use retir	0 a)			•	
avant, II	ပိ	17. Father's Name (First, Middle, L	ast)		Neve	Worked	18. Mothe	or's Name (First, Mic		n Sumame)	
ic av	To B	Melvin Vincent	T.ee				Etta	Marie Uv	rodi		
r other trsumatic av	-	19a. Informant's Name/Relationsh			19b. Mailir	g Address (Stree		or or Rural Route No		or Town, State, Z	Tip Code)
er tra		Etta M. Uwadi/M	lother		5005	70th Pla	ce Hva	ttsville,	MD 2	0784	
r of		20a. Method of Disposition 1 Burial 2 □ Cremation	2 Dameual from Stat	20b. Plac	ce of Dispo	sition (Name of natory or other pi		Date		ocation - City or	Town, State
ury o		4 □ Donation 5 □ Other (Sp			Linco	oln Ceme	tery 1	2/1/2005	Bre	ntwood,	MD
any injury or o once.		21. Signature of Funeral Service L	icens		22	. Name and Add	ess of Facilit	Fort Lin	coln	Funeral	Home
# a		23a. Part . Enter the disease, or o	Tell		34	01 Blad	ensbur	g Rd. Bre	ntwoo		
=	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a conseque							
burial-transi	al Exe	cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a conseque							
tached for use as the burial-transit	dical	that initiated events	d	e of pregnanc 2 ∐ Fetal d	ey eath 3	Ectopic pregnan Other (specify)	су			23d. Date of deline	very Day Year
be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	e of pregnanc 2 ∐ Fetal di at time of dea	ey seath 3 th 5	Other (specify)				Month use contribute to	Day Year the cause of death?
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			1 ⊶ For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of rtificate o	Health a f Death	nd Mer		pierre 05	40224
			1. Decedent's Name (First, Middle, Last)				2.	Date of Dea	ith	3. Time of Death
	Physic /Medi		Evelyn D. I	Lurty				No	Month Ovemb	er 25,20	005 3:15p M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of	Death		4c. County of De	
			Laurelwood			Elkto	on			Ceci	1
	Funeral		5. Social Security Number 6. Se	TM SEE		If Under 1 Yea		Min	Date of Birth (Month, Day	9. E	Birthplace (State or Foreign
	Director		100-10-2403	90	Yrs.			Ma	arch	26,1915	Birthplace (State or Foreign Country) PA
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	f sho	ō	MD Cecil		orth						1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number	L IN	OLUI	10f. Zio Code				log. Citizen of What	
	Sa or	0	112 Lakeside Dr	ri vo		21901				U.S.A.	Country
	ns 23	by Funeral	11.2 Lakeside Di	12. Was Decedent Ever in U.	S. 13. V			in? (Specify			merican Indian,
' O	fler of	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	1	Was Decedent of Yes, specify Co		Puerto Rica	an, etc.)	Black, Wi	
21215-0036	urs a		3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 25xN	lo Specify:			Specify:	White
Ō	s 1 and 2 should be filed within 72 hours after death with the Maryland f Haelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanter must be rediffed at	Completed	15. Decedent's Edu		16a. Deced	ient's Usual Occ	upation			16b. Kind of Busines	ss/Industry
2	hin 7	ple	(Specify only highest grad	College (1-4or 5+)	life. L	kind of work dor DO NOT use reti	ne during most red)	of working			
2	filed with Hygiene. other than	Ö	12			Bookl	ceeper			Nurse	ery
Maryland	al Hy Toth	Be (17. Father's Name (First, Middle, Last)				18. Mother	's Name (Fi	rst, Middle, i	Maiden Sumame)	
<u>ya</u>	Ment Ment arked	2	Lewis Alfred Da	aniels			E1	isqbe	eth L	amb-Bent	on
and a	2 should be f and Mental H is marked of raumatic eve		19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailin	g Address (Stre	et and Number	or Rural Ro	ute Number	r, City or Town, State	, Zip Code)
≥ .	and m 27 ser tr		David Lurty/Sor				idge S	t.,Pa	arkes	burg, PA	19365
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	1	ace of Dispo	sition (Name of natory or other p	(ace)	Date		20c. Location - City	
<u>Ĕ</u>	Pag ment ant: I		'4 □Donation 5 □ Other (Specify)		. Fei	ris In	nc. N	ovem]	ber 2	g, West	Chester,
at	permit. Departrimports any inju		21. Signature of Euneral Service Licens	99		. Name and Add				PA	
0	8958		XXXXX			Andrew					21021
			23a. Part1. Enter the disease, or sample shock, or heart failure. List only or	ications that caused the death	. Do not ent	er the mode of d	ying, such as c	ardiac or re	Spiratory arr	On MD est,	21921 Approximate
	Physician		Immediate Cause (Final	CA O							Interval Between Onset and Death
į .	/Medical		disease or condition resulting in death)	Due to (or as a consequ	lence of):						Una
	Examiner			CHE							vnk
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):	-	·				
	cate be executed physicien and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	HIN							VnK
ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ence of):						
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68	lificat g ph) as th	1 0 1									
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		e nec mon				23d. Date of d	elivery
Ω.	death e atte	icia	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de		Ectopic pregnan Other (specify)				Month	Day Year
O.	tt the d by the tached	hys	9 🗆 Unknown X	9☐ Unknown							
ď.	requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	by P	Part II. Other significant conditions con	ntributing to death but not resu	lting in the un	iderlying cause g	given in Part I.		23e. Did tob	pacco use contribute	to the cause of death?
ĕ	w require been sig should b	edt							1 🗆 Ye	es 2 □ No 3 □ F	Probably 4 Onknown
		Completed						-	24a. Wasa		autopsy findings available
æ	The law cate has b page 2 st	E O						-	autops	y prior to death?	completion of cause of
ta		0	25. Was case referred to medical				26 Place o		1 ☐ Yes 2		es 2 No
5	Physician: this certific ral director,	0 8	eyaminer?	lospital:		3 DOA				ence 6 Other (Sp	anife)
of	a Ph	Ë	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inj	ury at			w injury occurred	ecity)
<u></u>	Aft.	atlo	1 Alatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ∐Yes 2∐No	0			
Division	Atter	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	et, factory, office	9			reet and Number or F	Rural Route Number,
á	all or	Sert	4 Homicide	building, etc. (Specify,)				City or Town	, State)	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera		29a. Certifier 1 Certifying Phys	sicien: To the best of my know	vledge, death	occurred at the	time, date and	place, and	due to the ca	use(s) and manner a	as stated.
	se Ho se Fu se Fu	edical	(Check only 2 Medical Examinate)	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my	opinion, death	occurred a	t the time, da	ate and place, and du	ue to the cause(s)
	To th To th Comp	×	29b. Signature and title of certifier	1		29c. Licer	nse number		29	9d. Date signed (Mor	nth, Day, Year)
			10 ml	tolul n	b	Dos	5531	<		11-28-	05
	.1		30. Name and address of person who co		23a) (Tyne F	Print)	الحدرر	J		11-28	
	4		322 East (Cecil Ave.	, (-, 100, 1	Doc Print) North	9,5	4 N	10 2	1901	
e.	Sta	ite			nte *			1.4	- 6	· · · · · · · · · · · · · · · · · · ·	
	Registr	7.6	NUV 2 9 2005	32. Registrar's Signat	ele						

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005 :30AM **Physician** herene Sidner /Medical 4c. County of Death Prince George's Renaissance Gardens (Riderwood Village Silver Spring Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth
July 19,1923 7. Age (In yrs. last birthday) 5. Social Security Number 128-14-0571 **Funeral** 82 1XM 2□F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or than "natural", or Itams 23a or 28a-f show the Medical Exercitive rough be notified at Prince George's 1 ☐ Yes 2√☐ No Maryland Silver Spring 10g. Citizen of What Country? 10f. Zip Code Street and Number 20904 United States 3160 Gracefield Road, #1413 death v Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Anned Forces? 1 ∱3 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electronics Engineer Electronics permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other it any injury or other traumatic event, Ita once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Be Levine Rosenfeld ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3158 Cardinal Drive Westminster, Maryland 21157 19a Informant's Name/Relationship (Type, Print)
Tris Katz – daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gardens 11/27/2005 Falls Church, Va. 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Funeral Se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heresclerofic montho Proysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Be Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? ō 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificete has 2/2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onle one funeral director, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No ours after death.
neral Director: Af investigation 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Indedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License rumber title of certifie 29b. Signature ar 05 10 cause of death (Item 23a) (Type, Print) 30 Name and a ress of personal completed cause of geath (New 2014) (1996). Merritt, MD 3160 Gracefield Road Silver Spring, Maryland 20904 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 29 2005 Registrar

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Mont

32. Registrar's Signature

			1 - For State Registrar	State of M	aryland / [Departme <i>Certifica</i>	ent of H	lealth a Death	nd Menta	al Hygiệ) 5	+022	7
*	Physic	an	Decedent's Name (First, Middle,						Mo	te of Death onth	Day	Year	3. Time of De	eath .
	/Medi		Stephen Sco							ember			1910	М
1.	Examir		4a. Facility Name (If not institution, s Anne Arundel Med:				apoli	Location of	Death			inty of Death Arun		
	Funeral	-		. Sex 7. Ag	ge (In yrs. last bir	thday) If Und	der 1 Year	If Under 2		te of Birth		9. Birth	nplace (State or F	oreign
*	Director		505-50-8839 Usual Residence of Decedent	XX ^M 2□F	03	Yrs.	Days	Hours	Min. Dec	onth, Day, Ye	194	Linc	oln, Nel	ras
	d within 72 hours after deeth with the Maryland Jiene. r then "natural", or items 23a or 28a-1 ehow Ite Madical Examinar must be notified at	2	10a. State 10b. County Maryland Anne At	runde1	10c. City, Town								10d. Inside City I	
	the N	Funeral Director	10e. Street and Number				Zip Code			100	Citizen	of What Cou		
	3a or	0	1625 Parkridge (Circle, Apa	rtment 1		114					1 Stat	•	
	deeth	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De	cedent of Hi	spanic Origi	in? (Specify Ye	s or No-	14. [Race - Amer	ican Indian,	
9	after or its	교	1 Never Married 2 Married	Armed Forces 1			2 57 % o	Specify:	Puerto Rican,	etc.)		Black, White	o, etc.	
Maryland 21215-0036	hours urai',	d by	3 Widowed 4 XX ivorced	Year or Dates:	63-67	1				1		Wh	ite	
15	n 72 nat	iete	15. Decedent's (Specify only highest	Education grade completed)	16a.	Give kind of life. DO NOT	work done o	during most of	of working	161	b. Kind o	of Business/fi	ndustry	
12	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 4		count					Tnsı	ırance		
ğ	Hyg Hyg ent,	0	17. Father's Name (First, Middle, La	st)					's Name (First,	Middle, Mai				
/lar		To B	Glenn Earl Lo	7e11				Edith	n Lavi	na Su	ımmeı	rs		
lan	s 1 and 2 should f Health and Mer frem 27 ie marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Addre	ss (Street a	and Number	or Rural Route	Number, C	ity or To	wn, State, Zi	ip Code)	
	and ealth m 27		Cynthia Jo Gioro	lano/daught				ad, Ar	ndover,					
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 📆 💇 emation 3	☐Removal from State	cometa	Disposition (for y, crematory of	iame of r other plac	θ)	Date	200	c. Location	on - City or T	own, State	
ţ	t. Partmen		4 □Donation 5 □ Other (Spe	The state of the s	Metro	Cremat		man and a second	1/26/05	Ва	ltin	nore,	MD	
Bal	permit. Pag Department Important: i any injury o once.		21. Signature of Fine all Service Lic	Stalt	1	Harde	sty F		L Home, ie, Anna		мт	21/10	1	
8760,	Physician /Medical Examiner but side paral-transit the private from the pr	Ical Examiner	Immediate Cause (Fin disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence	of):	245 N	rysep	Pithelia	1 ne	10, 10.	Sm	2 mil	145
P.O. Box 68	t the death certifi by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other					1	Date of delive	∕ery Day Yea	ır
	quires tha n signed I uld be det	Ď	Part II. Other significant conditions	contributing to death b	out not resulting in	n the underlying	cause give	en in Part I.	23	e. Did tobac 1 □ Yes			the cause of deal	
Division of Vital Records,	0 = 0	Completed			-					a. Was an autopsy performer Yes 2	f?	prior to co death?	opsy findings ava ompletion of caus	
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?						of Death (Chec					
7	Physician: this certific al director,	၉	1 □ Yes 20 No	Hospital:		·		4 LI NUIS	sing Home 5				fy)	
ū	ing P	5	27. Manner of Death 1- Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of nju ry	28c. Injury Work			scribe how	injury oc	curred		
visio	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer.	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be .	jury - At home, fa	rm, street, fact		fes 2 □ No	28f. Loc	cation (Stree	t and Nu	ımber or Rur	al Route Number	r,
ā	Hospital or 24 hours efte Funaral Dir tely filled in I													
	To the Hospital within 24 hours e To the Funeral Completely filled	edicai	(Check only one)	Physician: To the best aminer: On the basis of and manner st	of examination an	d/or investigati	ed at the time on, in my op	e, date and pinion, death	place, and due n occurred at th	e time, date	e(s) and and plac	manner as s ce, and due t	stated. to the cause(s)	
	To th withir To th	ž	29b. Signature and title of certifier	2		2	9c. License	number		29d.	Date sig	ned (Month,	Day, Year)	
			Janine	lerens	MD		055	830	<u> </u>	M)Ve	wher	26,200	1
			30. Name and address of person who Seam well	o completed cause of a	death (Item 23a) (900 BS)	(Type, Print)	lood	#300	>, Ame	apoli.	1 1	10 2	140/	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 8	32. Registr	rar's Signature	A	10			/	1			

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment o				iene	5 4	0228	
ı	Physici	an	Decedent's Name (First, Middle, I	,			_		Date of Deat Month	h Day	Year	3. Time of Death	
	/Medic	al	AMANDA MARQUEZ 4a. Fecility Name (If not institution, of		ar)	4b. City. Tow	m, or Location of	of Death	Novembe	4c. County	2005	2:50 p M	
	Examir	ier	Sligo Creek Nu				a Park			Montg		7	
	Funeral		Social Security Number		Age (In yrs. last birthday) If Under 1 Y	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birthp	place (State or Foreign	
	Director		213-33-3655 Usual Residence of Decedent	1 M 2 M F	93 Yrs.				Oct. 23	, 1912	E1 S	Sálvador	
	yland Now		10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City Limits	
	e Mar	ctor	Maryland Montgo	mery	Takoma	Park						1 X Yes 2 □ No	
	or 28	Directo	10e. Street and Number			10f. Zip Co			10	0g. Citizen of \	What Cour	itry?	
	eath v	eral	600 Domer Avenue	12, Was Decede	nt Ever in IIS 13		912	ain? (Spec	offy Von or No-	U.S.A	e - Americ	ean Indian	
20	after d	Funeral	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2	S? XINo	Was Decedent If Yes, specify			Rican, etc.)		ck, White,		
Š	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28e-f ehow the Modicel Examilier chart by challied at	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date	s:	12XIYes 2□	No Specify:			Specify	His	spanic	
<u>.</u>	n 72 h "natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece (Give	edent's Usual Od e kind of work do DO NOT use re	ccupation one during mos	t of workin	g	16b. Kind of B	usiness/Ind	fustry	
212	i with	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)	maker	3.00)		1	:Own	Home		
פ	e filed al Hyg l'othe vent,	BeC	17. Father's Name (First, Middle, La	st)			18. Mothe	er's Name	(First, Middle, A				
<u>X</u>	Ment Ment arked	To	Teodoro Bernal						rquez				
Mar	d 2 sh th and 7 is rr treur		19a. Informant's Name/Relationship Ennio Marquez -						Route Number,			nd 20901	
ē,	Heal Heal tem 2	1	20a. Method of Disposition		20b. Place of Disp					20c. Location -			
Ë	Pages nent of nt: If I		1 N Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Special Control of the Con		Gate of			11/2	9/2005	Silver	Spri	n . MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than. Instural; or Iteme 23a or 28e-1 show amy injury or other treumatic event, the Marical Examinet may be notified at ance.		21. Signature of Funeral Service Lic	ensee	2	2. Name and A	ddress of Facilit	y Gas	ch's Fu	neral 1	Home,	P.A.	
	205 2 9		Jalanie / tron	17					, Hyatt		, MD		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	i line.			cardiac or	respiratory arre	ost,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		nic Pulmonar	y Fibro	sis						
	Examiner		Due to (or as a consequence of): h Hypertensive Heart Disease										
	sit od	iner	if any, leading to immediate cause. Enter Underlying										
	and and II-tran	Examiner	that initiated events resulting in death) Last		Disease						_		
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical E		d	· · · · · ·								
9	fiftcet ng phy as the	Medic	15.55141.5										
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetel death 3	□Ectopic pregna				23d. Dai	te of delive	ny Day Year	
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9□Unknown		Other (specify	y)					-u,	
<u>.</u>	The law requires that the de ste has been signed by the a page 2 should be detached i	by Ph	Part II. Other significant conditions	contributing to death	n but not resulting in the	underlying cause	given in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?	
rds	equires en sign	ed b							1 □ Ye	s 2□No	3 Prob	ably 4 📉 Unknown	
ecords,	e law requ has been je 2 shoul	Completed							24a. Was ar autops	/ 1	Were autop	osy findings available inpletion of cause of	
		Con		·					perform 1 Yes 2	ied? X No	death? I 🗌 Yes		
Vital	sicien: certific rector.	o Be	25. Was case referred to medical examiner?	Hospital:			Cthor		(Check only one				
0	y Phys er this eral dii		1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpa	njury 28b. Time	of 28c.	Α <u>ΙΑΙ</u> Νυ Injury at		e 5 Reside 8d. Describe ho			1	
<u>0</u>	otending I death. ctor: After y the funer	atlo	1 X Natural 5 Pending 2 Accident investigat	ion	Day Year) Injury		Work? 1 ☐ Yes 2 ☐ I	No					
Division of	after de Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of	Injury · At home, farm, si etc. (Specify)	reet, factory, off	lice	28	Bf. Location (Str City or Town	eet and Numb , State)	er or Rura	l Route Number,	
_	pitel ours a lerel Dilled i		29a. Certifier 1 Certifying	Physician: To the he	st of my knowledge, dea	th occurred at th	o timo dato an	d place, as	ad due to the ea	use(a) and ma		atod	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner	s of examination and/or i	rvestigation, in r	my opinion, deal	th occurred	d at the time, da	te and place,	and due to	the cause(s)	
	To the Hospitel within 24 hours a To the Funerel C completely filled	Me	29b. Signature and title of certifier			29c. Lic	cense number		29	d. Date signer	d (Month, I	Day, Year)	
^	1		1 Hu	MIU		D	0046998	3	1	Novembe	r 28	, 2005	
K	(4)		30. Name and address of person wh	-			a	, -			_	1 00-00	
	Sta	te.	Steven T. Tee, 31. Date filed (Month, Day, Year)	■ Regi	15 Hamilton	Street	, Suite	1, I	Hyattsv:	ille, M	la r yla	ind 20782	
	Registi	_	NOV 2 9 20	05 Block	W K	A.							

				ate of Maryland / Depart	artment of Health and Natificate of Death	Mental Hygie	9
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) OSCAT 4a. Facility Name (If not institution, give street)	Muhammad	4b. City, Town, or Location of Death	2. Date of Death Month 11/1	7/05 Year 3. Time of Death 143 M
	Funeral Director		1617 Taylor Ave. 5. Social Security Number 316-14-2272 1巻 M 2	7. Age (In yrs. last birthday)	Ft. Washingto	n	Prince Georges
	72 hours after death with the Maryland netural; or items 23a or 28a-1 show dical Examinat must be notified at	rector	Usual Residence of Decedent	orges Ft. Wash			10d. Inside City Limits 1 □ Yes 2 No
9	after death with the Marylar or Items 23a or 28a-f show infrer must be notified at	Funeral Director	An	⊒Yes 2. TNo	20744 Was Decedent of Hispanic Origin? (Sp. 17 Yes, specify Cuban, Mexican, Puerto	U	14. Race - American Indian, Black, White, etc.
215-003	c * @	Completed by	15. Decedent's Education (Specify only highest grade comp	par or Dates:	1 ☐ Yes 2 ☒ No Specify: dent's Usual Occupation kind of work done during most of work DO NOT use retired)	sing 16	Specify: black bb. Kind of Business/Industry
Maryland 21215-0036	be file ital Hyg id othe event,	То Ве Соп	9 17. Father's Name (First, Middle, Last) Clem Freeman	unen	nployed 18. Mother's Nam Rose	r e (First, Middle, Ma Freema	
	is 1 and 2 should by Health and Men Item 27 is marke other traumatic.		19a. Informant's Name/Relationship (Type, Pri Wali Muhammad/ soil 20a. Method of Disposition	· ·	ng Address (Street and Number or Run Taylor Ave., F	t. Washi	ington, Md. 20744
Baltimore,	arlment cortant: #		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ☐	Maryland	natory or other place) Nat. Cemet.11	-23-05	
	icate be executed XI Deprivation of the part of the pa	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	s that caused the death. Do not ent se on each line.	1 Kennedy St.,	N.W. Was or respiratory arrest	Shington, D.C.2001 Approximate Interval Between
O. Box 68	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	in the past 12 months?]Ectopic pregnancy] Other (specify)		23d. Date of delivery Month Day Year
<u>a</u>	w requires that been signed b should be deta	ě	Part II. Other significant conditions contributing	ng to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to the cause of death?
ital Rec	en: The law rtificate has b tor, page 2 sl	e Completed	25. Was case referred to medical		26. Place of Death	24a. Was an autopsy performed 1 Yes 25	
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification; To B	1 √ Natural 5 □ Pending 2 □ Accident investigation	Date of Injury (Month, Day Year) 2EP/Outpatien 28b. Time of Injury	t 3 □ DOA Other: 4 □ Nursing Ho 28c. Injury at Work? M 1 □ Yes 2 □ No		e 6 Other (Specify) injury occurred
Divi	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		4 Homicide determined 286. 29a. Certifier 1 Certifying Physician:	Place of Injury - At home, farm, stre building, etc. (Specify) To the best of my knowledge, death	occurred at the time, date and place	City or Town, S	e/s) and manner as stated
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29b. Signature and title of certifier	n the basis of examination and/or invidence stated.	estigation, in my opinion, death occurr 29c. License number	ed at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year) Vender 27, 2005
	1			or ,M.D. 3001	Print) Hospital Dr,C		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2005	3. Registrar's Signature	de)		

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death AMEND#26perMD11/29/05, BMW, McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Martinez 23, 2005 November 6:30 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 3809 Glen Eagles Drive Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☑ M 2 ☐ F Yrs Director 83 118-40-3704 Argentina Usuel Residence of Decedent 5.1 end 2 should be filed within 72 hours efter deeth with the Marylend Health end Mental Hygiene.
16 marked other than "naturel", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or liems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3809 Glen Eagles Drive Funeral 20906 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 X Yes 2 □ No Specify: Specify \$ 3 Widowed 4 Divorced Yeer or Dates: Argentinian White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) District of Columbia 5+ Educator Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martinez Carmen Mon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martinez Wife 3809 Glen Eagles Drive Margaret Silver Spring,MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date Department of important: If it any injury or on page. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/28/05Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Colley Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Pert1 Pinter the disease, or complications tolar caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner to (or as a consequence of): Physician/Medical Examiner anding physician end use es the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No s been signed to should be detail þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residen Cother (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient =2 3□ DOA After thi funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation efter death.

Director: Aft d in by the fur М 1 Tyes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33475 30. Name end address of person woo completed cause of death (Item 23e) (Type, Print) MRIN AUID reene 32 Registrer's Signature 31. Date filed (Month, Day, Year) NOV 2 9 State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Lillian 8:05P. M Rogers Klepper Margolius November 27, 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Potomac Manor Care 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Montgomery 5. Social Security Number 094-28-5462 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan. 11,1903 9. Birthplace (State or Foreign **Funeral** Days Min. 1□M 2/□F Hours 102 New York, N.Y. Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Localion 10d Inside City Limits worde | njuty or other traumatic event, the Mudical Examiner must be notified at Maryland Montgomery Potomac 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 10714 Potomac Tennis Lane, #169 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 □ Yes 2 No White 2 lf Yes, Give Year or Dates: 3 Nidowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be in nent of Health and Mental I int: If Item 27 is marked o Joseph Rogers Hattie Ruda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence R. Klepper -son 5855 Los Verdes Court Bradenton, FL Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 11/30/2005 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature Jun 11 rvice Licentee Dőnald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 any Ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advance **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Month Year Day 5 Other (specify) P.O. this certificate has been signed by the a al director, paga 2 should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2. No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural To the Hospital or Attending
within 24 hours after deeth.
To the Funeral Director: Afte completely filled in by the fune 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D0054566 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SULLIKE Scritch FLORUX ROLLING Toffarcio 31. Date filed (Month, Day, Year) NOV 2 9 32 Registrar's Signature 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 22, **Physician** Evelyn P. McPherson 2005 6:45 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 1166 River Bay Road Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🔯 F North Carolina 89 Yrs. Director 241-10-9160 1916 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits r then "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1166 River Bay Road 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Fiscal Scientist E.P.A. 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ie marked of ss 1 and 2 should be of Health and Mental Item 27 is marked John A. Payseur Violet M. Stowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond L. McPherson/Husband 1166 River Bay Road Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H
important: if ite
eny injury or ott November 26, 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Fineral Service Licensee Barranco & Sons P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. 1110ms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE CONGESTIVE **Physician** /Medical Examiner Securities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 X No 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death sequence at the time, date and place, and due to the cause(s) and framer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Thomy walsh mo D23867 30. Name and address of person who completed cause of death (Item 23a) Type, Brint)
7740MAS WALSH MD 277 DEMMSWLA FWM ROAD ARNOLD MD, 21012 32. F. gistrar's Signature 31. Date filed (Month, Day, Year) State NOV 28 2005 Registrar

		For State Registrar		State of	Marylar		artment of				61	100	40233
		Decedent's Name ((First, Middle, L	ast)			Timodic c	Dean		Date of De	Reg. No.		3. Time of Death
hysicia				RA HILI	MAN M	A C C E V				Month	Day	y that	
/Medic xamin		4a. Facility Name (If n				HOOLI	4b. City, Town	n. or Location		JUVem	-	County of Dea	
Admin		Manokin Ma					Princes					Somerse	
neral		5. Social Security Num	nber 6.	Sex	. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Unde		Date of Bir (Month, Da			thplace (State or Foreigountry)
ector		214-34-502	24	1 □ M 2 2 F	8	33 Yrs.	Months Da	ys Hours	Min. 01	/05/1	922	Mar	vland
	-	Usual Residence of D			100 0	T							
any injury or other treumstic event, the Mudical Examinar must be notified at ones.	2		I0b. County			y, Town or Lo							10d. Inside City Limits
100	ecto		Somerse	<u>t </u>	Prir	icess A							
2	吉	10e. Street and Numb					10f. Zip Cod				10g. Citi	izen of What Co	ountry?
	Funeral Director	11974 Edge	enill Te	12. Was Dece	tant Creation II	6 40	21853		National (Committee)			USA	
	S	11. Marital Status 1 Never Married	I 2□ Married	Amed For	ces?		Was Decedent of If Yes, specify C	uban, Mexic	an, Puerto Ric	an, etc.)		14. Race - Ame Black, Whit	
	by	3 Widowed 4	_	If Yes, Give	,		1 ☐ Yes 2 X !	No Specif	y:			Specify:	rabá to
		1:	5. Decedent's E	1		16a. Dece	dent's Usual Oc	cupation			16b Ki	ind of Business	White
	ple	(Specify Elementary/Second		rade completed) College (1-	40151)	(Give	kind of work do DO NOT use rei	ne during mo ired)	ost of working				,
	Completed	8	ialy (0-12)	College (1-	401 5+)	Nurse	s Aid				Hea	ılth Cai	re
	0	17. Father's Name (Fi	irst, Middle, Las	t)			7	18. Mot	her's Name <i>(F</i>	irst, Middle,			
	ToB	Reginald W	V. Hillr	nan				Anna	Menzel	_			
	1	19a. Informant's Nam	e/Relationship	(Type, Print)		19b. Mailir	ng Address (Stre	et and Num	ber or Rural R	oute Numb	er, City o	r Town, State.	Zip Code)
		Beatrice S	Seymour	(sister))	1601	Horner	Road,	Woodbr	idge,	VA	22191	
		20a. Method of Dispos		☐Removal from S		lace of Dispo	sition (Name of	olace)	Date		20c. Lo	cation - City or	Town, State
		° 4 □Donation 5				Paul'	s Cemet	erv	11/30/2	005	Mari	on Stat	ion, MD
ouce.		21. Signature of Fune	Service Lice	ensee	- 1	HC	Name and Ad Iloway 3 Linde	ress of Fac MeIsor	n Funer	al Ho	me,	P.A.	
al er	i Examiner	23a. Part 1. Enter the shock, or heart filmmediate Cause (Fir disease or condition resulting in death) Sa usually list and if any, leading to immease. Enter Underly Cause (Disease or injubat initiated events resulting in death) Las	Riuns ediate ing ury	Due to (c	r as a conseq	uence of):	00	one.	. 7	Market States			Approximate Interval Between Onset and Death
	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	onths?		th 2 ☐ Feta nt at time of d	I death 3	Ectopic pregna				2	23d. Date of del Month	ivery Day Year
	by P	Part II. Other significa	ant conditions	contributing to dea	th but not res	ulting in the ur	nderlying cause	given in Part	il.	23e. Did to	bacco u	se contribute to	the cause of death?
		Deline	phoe	y-fie	Dec	cker	nie			101	es 2	BNo 3□Pr	obably 4 Unknown
1	Completed	Essen	cufree	2 Sta	pert	euse	m			24a. Was		24b. Were au	itopsy findings available
	E	Fa '0	1	- 7		_					rmed?	death?	completion of cause of
	0	25. Was case referred	to medical	0 /10	rice	K		26 Plan	ce of Death (C	1 Yes		1 🗆 Yes	2/23 No
		examiner?										Cinther (Spec	cufu)
	Position of the statement of the stateme												sity)
	-	27. Manner of Death	5 Pending	(Month	, Day rear,		M 1	Yes 2	No				
	-	27. Manner of Death 1	5 Pending investigatio 6 Could not to determined	(Month		om <i>e</i> , farm, stro	M 1			Location (S City or Tox	Street and m, State)	d Number or Ru	ıral Route Number,
	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	investigation 6 Could not to determined	28e. Place of building	of Injury - At hog, etc. (Specify	y) 	eet, factory, office	time, date a	28f.	due to the	m, State)	and manner as	stated
	-	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2)	investigation 6 Could not to determined Certifying P Medical Examined	28e. Place of building	of Injury - At hog, etc. (Specify	y) 	eet, factory, officence, factory, time, date a	28f.	due to the	m, State) cause(s) date and	and manner as	stated, to the cause(s)	
	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	investigation 6 Could not to determined Certifying P Medical Examined	28e. Place of building	of Injury - At hog, etc. (Specify	y) 	n occurred at the restigation, in m	e time, date a y opinion, de	28f. and place, and path occurred a	due to the	m, State) cause(s) date and	and manner as place, and due e signed (Month	stated, to the cause(s)

DHMH 17 Rev 1/2001

State Registrar

ET

			For State Registrar	State of M		partment of I Certificate of			giene 2005	40234
			Decedent's Name (First, Middle, Li	ast)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Hazel Geneva	Milbourn	е			Month NOV -	Day Yee 24 200	A.4
	Examin		4a. Facility Name (If not institution, gi				or Location of Death	21018	4c. County of De	
			2381 Worceste	r Highwa	У		oke City		Worces	ter
	Funeral Director		212-40-7828	Sex 7. A	ge (In yrs. last birthd 76 Yrs	Months Days		8. Date of Birt (Month, Da Dec •	^h Year) 1928 1	Birthplace (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	sath with the Marylan s 23e or 28a-f show	ō	MD Worces	ter	Pocomok					1 Yes 2 No
	the 28a	rect	10e. Street and Number		100011011	10f. Zip Code			10g. Citizen of What	
	h with	Funeral Director	2381 Worceste	r Highwa	У	2185	51		USA	
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces		13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No	14. Race - Ar	nerican Indian,
215-0036	ilied within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23e or 28e-f show ent, Item Medical Examination in the modifical and	۵	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2X If Yes, Give Year or Dates	‰ ∘	1 ☐ Yes Ž∭No		rican, etc.)	Specify: B	
5-0	72 h	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. De	ecedent's Usual Occu	pation during most of work	ina	16b. Kind of Busines	ss/Industry
2 121	y within 7 jiene. r then "n	шb	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use retire		- 1		
25.	illed withi Il Hygiene. other then	ပိ	17. Father's Name (First, Middle, Las	1	U Dire	ctor of			Board of Maiden Surname)	Education
and and	e d la la la la la la la la la la la la la	Be.	Sippilo Steve							
202	d 2 should be th and Mental the marked of treumetic ever	일	19a. Informant's Name/Relationship		19h M	ailing Address (Street	Addie C	Cottmar	City of Town Ctate	Tin Control
Nar S	d 2 h a 7 is		Joyce Cottman		295	11 Deal	Tsland F		er, city or rown, State	Anne, MD
, , , ,	of Health item 27 other tr		20a. Method of Disposition		20b. Place of Di	sposition (Name of		Date	20c. Location - City	
9	bages ent of nt: If i		XXBurial 2 Cremation 3 L 4 Donation 5 Other (Spec		Green	crematory or other pla Acres Me	em. PK. 1	2/1/05	Salisbu	
ට රට Baltimor	permit. Pages 1 Department of F Importent: If ite eny Injury or ot		21. Signature uneral e vice l			22. Name and Addre	ess of Facility Watson	Funera	al Home	
'			23a. Part . Enter the disease, or cor	nolications that cause	ed the death. Do not	1618 Wes	t Rd., S	alisbu	ry, MD 2	21801 Approximate
			shock, or heart failure. List only	one cause on each	line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aff 4 PE	RTENSI.	VE CA	2 DIO VI	15CVL	AR	425
	Examiner		-	DuMe to (or a	s a consequence of):		Di	SEAS	2	
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):					
00	uted d ansit	ᇤ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
120	cate be executed physician and the burial-transit	Examiner	resulting in death) Last	Due to (or a	s a consequence of):					
76	ate be physicia the bur	dical		d						
17 S			V5.555							
ARN Box	The law requires that the death certifi tte has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No			3 □Ectopic pregnanc 5 □ Other (specify) _	;y		23d. Date of d Month	lelivery Day Year
2000 2003 8, P.O.	that the de ed by the a detached	Phy	9 Unknown							
77 0	quires tha en signed uld be de	þ	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cause gr	ven in Part I.			to the cause of death? Probably 4 Dunknown
E 300	aw requi ss been s 2 should	Completed						24a. Was	an 24b. Were	autopsy findings available
P. S. A.	The I	Eo						autop	med? death?	
FV.		a	25. Was case referred to medical				26. Place of Death		2 No 1 1 Ye	es 2K No
2 >	d is	To B	examiner? 1 ☐ Yes 2 X ÎNo	Hospital: 1 Inpat	ient 2□ER/Outpa	tient 3 DOA Ott	her: 4 🗆 Nursing Ho		ence 6 □Other (Sp	pecify)
16 n of	ding Pt. h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury 28b. Tim		ry at		ow injury occurred	,,
Sion	Attending r death. ector: After by the fune	atle	2 Accident investigation	on		,]Yes 2□No			
7.0 K	after de Direct	Certification:	3 Suicide 6 Could not determined	286. Place of I/	njury - At home, farm, atc. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
A28	urs urs ara		29a. Certifier 1 Certifying P	hysician: To the bes	t of my knowledge, d	eath occurred at the ti	ime, date and place,	and due to the c	cause(s) and manner a date and place, and de	as stated.
I	the the	Medical		and manner s	tated.					
	Con Twit		29b. Signature and title of certifier	2		29c. Licens			29d. Date signed (Moi	
	1/3		115-	antia	non	- Late	00255	6	11-25	-67
	100		J.G. Santiano,			pe, Print) Pocomo	oke City	MD 21	1851	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 9	32. Regis	trar's Signature			2		
	4			The same of the sa	man ha	al harman				

				riease i	State of M						•		_	•	
			1 _ For State		State of M	arylar				Death	ivientai	7	11115	1.00	235
			Registrar 1. Decedent's Name (First	Middle Last)		Ce	lliica	ile oi i	Jealii	2 Date	Reg. No	0,000		e of Death
	Physici		ELIGIO MENE								Mon		ay Yea		
	/Medio Examir		4a. Facility Name (If not in		street and number)			4b. Cit	y, Town, o	Location of Dea	h	40	c. County of De		
1	Exami		Peninsula i	PRIMA	of medica	1/1	enter	<	Solis	Shird			Wicon	nico	
	Funeral		5. Social Security Number	6. Ser		e (In yrs.	last birthday)	If Und	er 1 Year Days	If Under 24 Hrs Hours Min		of Birth oth, Day, Year	9. B	irthplace (Sta	te or Foreign
	Director		625-86-9598		JM ZUF	68	Yrs.					30-1937		ILIPPI	NES
	land		Usual Residence of Deced 10a. State 10b.	County		10c. Cit	y, Town or Lo	ocation						10d. Inside	City Limits
	Manylan -f show	ō	DE	SUSSEX		CE	ORGETO	t.m						1 🔯 Y	es 2□No
	r 28a	irec	10e. Street and Number	DODDLA		J GL	ORGLIO		ip Code			10g. C	itizen of What (Country?	
	th wit	Funeral Director	301 N. RACE	STREE'	Γ				1	9947			USA		
	r dea	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Dec	edent of H	ispanic Origin? (S n, Mexican, Puer	specify Yes	or No-	14. Race - An Black, Wh		
36	or it	by Fu	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		1 ☐ Yes 2X☐ If Yes, Give	No	ł	1 🗆 Yes		Specify:			Specify:	ASIAN	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show he Medical Exeminar must be notified a	ed b		ecedent's Edu	Year or Dates:		16a. Dece	dent's He	ual Occup	ation		16h k	Kind of Busines		
15	in 72	piet	(Specify only	highest grad	e completed)	c.\	(Give	kind of v	rork done o	during most of wo	rking	100.1	Cilia of Dasiries	as industry	
212	d with giene er the	Completed	Elementary/Secondary	0-12)	College (1-4or 2	3+ <i>)</i>	QUAL	ITY	CONTR	OL SUPER	VISOR	POU	LTRY FA	ARMING	
	be filed tal Hygi d other event, I	Be	17. Father's Name (First, I	Aiddle, Last)						18. Mother's Na	me (First, A	Aiddle, Maide	n Sumame)		
yla	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	ပို	SANTIAGO ME				_			TEODORA					
Maryland	2 sh and is m raum		19a. Informant's Name/Re		,					and Number or R					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-1 show any njury or other traumatic event, the Medical Exemples coust be notified at once.		GREGORIA ME 20a. Method of Disposition		- SPOUSE	20b. F	The second second second			REET, GEC	RGETO Date		LAWARE		
Baltimore,	Pages nent of I int: if It		1 Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ C	nation 3 K	lemoval from State	MT	Place of Disponentery, crein ZION								
Ħ	ertme ortan		21. Signature V Funeral S		90 2 0	III				ss of Facility BC	0-200		LIPPIN		
B	Deportr Imports any no		1 Jun	~ X	feller					AIN STRE					804
			23a. Part1. Enter the dise shock, or heart failu	ase, or compli	ications that cause	d the deat							z y i i i i i i	Approxin	nate
J.	Physician		Immediate Cause (Finaf disease or condition	or Electionly of)(a v c	de a l	in f	arche	0					nd Death
7	/Medical		resulting in death)		Due to (or as			11,),	1	_				12	hours
н	Examiner	L	Sequentiafly list condition	s, l t		VOV	m	an	tem	Disen	75R			V.	Private
	bed isit	Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	▫▗▘	Due to (or as	a conseq	uence bt):		J						
	xecul and al-trar	xan	that initiated events resulting in death) Last	0	Due to (or as	a conseq	uence of):								
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai			1										
68	ires that the death certificate signed by the attending phys d be detached for use as the	edi													
Box	th cer tendir r use	Physician/Medi	IF FEMALE: 23b. Was decedent pregn	arit	3c. If yes, outcome			Ectopic	pregnancy				23d. Date of d	,	
	e dea the att	sici	in the past 12 month 1 Yes 2 No	57	4☐Pregnant a 9☐Unknown			Other (Month	Day	Year
P.0	d by teletach	P.	9 ☐ Unknown Part II. Dther significant of	anditions cor	tributing to death h	ut not roc	ulting in the u	ndorb in a		no in Clark (220	Did tobacco	use contribute	to the source of	of dooth?
ds,	signe d be d	p	Die		mellihs	ACTION 103	alleng er trie u	nderlying	Cause give	miniralli.	230		54	robably 4	
Ö	w requir been si should	Completed	Pa	CI	21.0						240	Was an	24h Wara	autopsy findin	as sucilable
Re	he lar e has	E G	- Ken	1	41100							autopsy performed?	prior to death?	completion	
ta	an: T tificat tor, pa	Be C	25. Was case referred to	nedical						26. Place of De	1 Check		1 □ Y€	s 20 No	
of Vital Records,	Physician: this certificantal director,	To B	examiner? 1 ☐ Yes 2 💢 No	F	lospital: 1 (Inpatio	ent 2 🗆	ER/Outpatier	nt 3 🗆 🖸	Othe				6 ☐Other (Sp	ecity)	
0	ng Ph ter th neral	Ľ.	27. Manner of Death 1 ☑ Natural 5 □	Pending	28a. Date of Inju	iry	28b. Time o Injury		28c. Injun Work			cribe how inju			
Si.	endite eath. or: Al	atic	2 Accident	investigation Could not be				М		res 2 □ No					
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	28e. Place of fn building, et	ury - At ho c. (Specif	ome, farm, str y)	reet, facto	ry, office		28f. Loca City	tion (Street alor Town, State	nd Number or I e)	Rural Route N	u <i>mber</i> ,
	pital ours a erai (Ce	29a. Certifier 1XC	artifying Dh	ician: To the best	of multi-	wledge deet	h access	d at the str	o data and all	nort des	to the activity	N and		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 M	edical Exami	sician: To the best ner: On the basis o and manner st	it examina	tion and/or in	vestigatio	u at the tim in, in my op	oinion, death occi	rred at the	time, date an	d place, and du	as stated. Ie to the caus	e(s)
	To the vithin To the To the Sompl	Me	29b. Signature and title of	certifier				2	9c. License	number		29d. Da	ate signed (Mor	nth, Day, Year)
	81.		> 	ulean	MD				1)4	11812		1/1	24/05		
-	1		30. Name and address/of	person who co	mpleted cause of c				<u> </u>	1011	1.1		7 -		
	2		J. Steve	Julin	- 1		10 Pine	Blut	+ Re	and Su	1135m	1 , mi	21801		
	Sta Registr		31. Date filed (Month Na	V2 9 20	05 32. Bygisti	ar's Signa	ture	for a			(,			

DHMH 17 Rev 1/2001

Elisic C21-86-95-78

Meneses,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40236 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Nov. 20, 2005 **Physician** Cecil Ρ. Ne1son 4:55a.m. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Sacred Heart Home Hyattsville P.G. Hours Min. July St. 1920 if Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country)
La. Funeral Months Days 578 54 0717 1□ M X□ F 85 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** Washington, D.C. D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1509 Channing St, N.E. 20018 USA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: Black 3 Nidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Librarian Catholic University 12years <u>5+ years</u> 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Larry Posey UNKNOWN 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Alouise Powell-Maclin / Niece 5031 13th St., N.E. Wash., D.C. 20017 20b. Place of Disposition (Name of cometery, crematory or other place)
Alarmony Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/28/2005 Landover, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
John T. Rhines Funeral Home Juan Smith 3015 12th St., N.E. Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cancer of Pancrease Months Examiner Due to (or as a consequence of): Physician/Medical Examiner ete hes been signed by the ettending physicien and pege 2 should be deteched for use as the bunel-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Lest Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabtes Mellitus Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Deep Vein Thrombosis completion of cause of death? 2 INC 1 Y65 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: Director: After 1 Naturet 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth thef 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type Print)
PERRY STREET MT. RAINIER, MD. 20712 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

NOV 2 9 2005

			For State Registrar	State of M	arylan		artment tificate					jiene eg. No.	05 4	0237
% (4.0°)	Physici		1. Decedent's Name (First, Middle	o, Last)		+	PIN	Co		·	2. Date of Dea	th Day	2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution			., .		7 i	Location of	_	14-4	4c. Co	unty of Death	
1.5	Function	lige .	University 8		e (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day		9. Birthpl	ace (State or Foreign
Ę.	Funeral Director		578–58-4335	1 □ M 2XX F	(60 _{Yrs.}	Months	Days	Hours	Min.	August 1	1945	Washi	ngton, D.C.
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
:	8e-fsh	Director	D.C.			Wast	ningtan							XXYes 2 No
:	With It	i Dire	10e. Street and Number 2651 Birrey P	lace, S.E. Apt.	#103		10f. Zip	Code	2002	20			of What Count J.S.A.	ry?
	be lied within /2 hours atter death with the Maryland Hygiene. Hygiene. do ther than "naturel", or items 23s or 28e-f show event, the Modical Examinal must be rediffed at	Funeral	11. Marital Status 1X Never Married 2 ☐ Marr	12. Was Decedent Armed Forces? ned 1 \(\text{Yes} 2 \(\text{X} \)			Was Deced		spanic Ori n, Mexicar	igin? (Spe n, Puerto I	ecify Yes or No- Rican, etc.)	14.	Race - America Black, White, e	otc.
215-0036	urel', o	d by	3 Widowed 4 Divorced						Specify:				of Business/Ind	ack
215-	hin 72 a. mar "nat	Completed by	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	(Give	dent's Usua kind of woi DO NOT us	k done a	luring mos	t of workii	ng	160. KIIIG	oi business/ind	ustry
121	lled wit hygiene her tha	Сод	12th grade 17. Father's Name (First, Middle,			<u>D</u>	mestic	Engi		ar's Name	(First, Middle,		sekeepin	3
lanc	d ala	To Be	Char	lie Davis, Sr.					10, 10,000		anche Pri		, , , , , , , , , , , , , , , , , , ,	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relations Yvette D. Prince				-				hington,			Code)
altimore,	Pages 1 a nent of Hea nut: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		C	lace of Dispo emetery, crei	natory or o	ther plac			26, 2005		ion - City or To	
Balti	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Funeral Service	Licensee							ollins Fur eshington			
			stick, or heart failure. List	complications that cause only one cause on each I	ine								2	Approximate Interval Between Opset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	OM I	nal	sep	Sis	021	C 70	Ischu	MIC	Bonel	opset and Death 4 weeks. 4 weeks.
4	Examiner		Sequentially list conditions	b. Upp	ver a	Lon	er.	ex.fy	emi	ty	15cher	nIA/	necrosis	4 weeks.
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):				(,		
760,	ate be executed nysicien and he burial-transit	cal Exar	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):								
	artificate ing phy e as the	ed	IF FEMALE:											
P.O. Box	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	⊒Ectopic pr ⊒ Other (sp				·	230	I. Date of delive Month	ry Day Year
ds, P.	ires that the signed by the detaction	ρ	Part II. Other significant conditi	ons contributing to death	out not res	ulting in the u	inderlying c	ause give	en in Part I	l.	23e. Did to	i		e cause of death?
Division of Vital Records,	law requires t as been signe 2 should be o	Completed									24a. Was		24b. Were autor	sy findings available
- Re		Com									autop perfor 1 Yes	med? 2 X No	death?	pletion of cause of
Vita	ician: certific rector,	o Be	25. Was case referred to medica examiner?	Hospital:		FD/0	-57.00	Othe	ar.		(Check only o			
o		-	1 Yes 2 12 No	28a. Date of Inj (Month, Date	ury	28b. Time of Injury		8c. injun Worl	4 IV		me 5 Resid 28d. Describe h)
sior	Attending F r death. ector: After by the funera	catlo	1 Natural 5 Pendii	gation			М	1 🗆	Yes 2 □		206 Leasting /6	Manage and A	tumbo a Dum	Route Number,
<u>N</u>	4 - 0 G	Certification:	4 ☐ Homicide determ	28e. Place of In building, e	tc. (Specif	y)	reet, factory	, oπice			City or Tow		WINDER OF HUIZ	HODIO MUNDON,
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurred westigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the deed at the time, of	cause(s) and date and pl	d manner as stace, and due to	ated. the cause(s)
A	To the within 2 To the complet	Me	29b. Signature title of certifie	Tan-	0		290	P-17	9 number 7723				igned (Month, I	
	(1)		30. Name and address of person	who completed cause of	death (Iten	n 23a) (Type,	Print)		CL-	, , 4	Bult	n i	ירוף ח	57
3	St	ate	Signund Tan, M.D. 31. Date filed (Month, Day, Year,) 2. Regist	rar's Signa	ITUES -	-5116	cal	211	ul	uni	100	v uu	
	Regist	rar	NOV 2 8 2	2. Regist	, K	April	(A)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle. 2 Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) CRCil North East If Under 1 Year If Under 24 Hrs. 1A5KI MD 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 6. Sex Birthplace (State or Foreign Country) 1**58** M 2□ F Months Days 179-26-471 2 Director 6, 1932 QUANNUILLE Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f shov traumatic event, the Mudical Examiner must be notified at 1 Yes 27 No Director Lancaster 1VILLE MARN the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 996 Valley 566 USA Items 23a d Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 70 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: white 3 Widowed 4 Divorced nature 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) welder/fabricator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stuart hillips Zeb Esther Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai 900.0. Pulaski Highway, North EAST MD Patricia 3395 Crouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Eagle Crematory Leola 17540 11-30-05 A □ Donation 5 □ Other (Specify) 21. Sign at re of Funeral Service Licen as 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-tran the attending physician and Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. signed E Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 As 2 No 3 Probably 4 Unknown ils certificate has been si director, page 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Tes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 ther (Specify) De this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 GNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signalore and title of certifier ٥ 29d. Date signed (Month, Day, Year) MI Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NUV 2 9 200

31. Date filed (Month, Day, Year)

oria Dimonson

32. Registrar's Signature

		1	For State Registrar	State of	Marylan		artment of F		and Mental H	lygiene Reg. No	100 1	+023	9
. Alle	Physicia		Decedent's Name (First, Middle JOAN	Last)	RAILEY				2. Date of NOVEME		ĭ, 2005	3. Time of 0115	Death M
	/Medic Examin		4a. Facility Name (If not institution	give street and nun	n <i>ber)</i>		4b. City, Town, o	r Location o	f Death	40	. County of Deal	th	
14	Examili	er S	SHADY GROVE HOS				ROCKVILL	E		M	ONTGOMER	RY	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 □ TF	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2	Min. 8. Date of (Month,	Birth Day, Year) Co	thplace (State o ountry)	r Foreign
	Director		217-13-7868	TOW ZX	65	Yrs.			01-29-	-1939	LIBE	ERIA	
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside Cr	ty Limits
	Maryl	ğ	MD HOWARD		COLU	MBIA						1 X Yes	2 🗌 No
	hours after death with the Maryland tural; or Items 23a or 28a-f show al Evan her must be invitified at	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?	
	th with		6243 BLUE DART	PLACE			21045				U.S.A.		
	ems ems	Funeral	11. Marital Status	12. Was Dece Armed Fo		.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Orig an, Mexican	gin? (Specify Yes or i, Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit		
36	s afte	by Fu	1 Never Married 2 Marr 3 Widowed 4 Divorced	ed 1 Tes If Yes, Giv Year or D	2 No		1 ☐ Yes 2 🙀 No	Specify:			Specify: BI	LACK	
Ö	be filed within 72 hours after death with the Marylan deliyylane. deliyylane. deliyylane. deliyylane. deliyethan "natural", or liems 23a or 28a-f show ach, the Madical Exam har maile and and ach.	ed b	15. Deceden		a163.	16a. Dece	dent's Usual Occup	oation		16b. l	Kind of Business	/Industry	
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212	d within giene. or then "	E O	Elementary/Secondary (0-12)	2yrs		OFFIC	E SECRET				IVATE		
힏	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle,	Last)					er's Name (First, Mid	dle, Maide	n Sumame)		
ylai		P	JAMES A. RAILEY						L DAYRELL			Zin Ondal	
Nar	d 2 should th and Mer 7 is marke traumatic	l	19a. Informant's Name/Relations						er or Rural Route Nu				20043
	s 1 and 2 f Health Item 27 other tra		ETHEL DIXON/D	AUGHTER	20b. F	Place of Disp	osition (Name of	- 1	DRIVE LAWE Date		Location - City or		70043
و	Pages nent of I int: If Ite		1 Burial 2 Cremation		State		matory or other pla	1	12/3/2005	GEI	RMANTOWN	.MARYLA	ND
Baltimore,			4 ☐ Donation 5 ☐ Other (S) AL		2. Name and Addre						
Ba	permit. Departr Importe sny Inj		2	5	1-	7	474 LAND	OVER R	ROAD LANDO			100000000000000000000000000000000000000	5
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that only one cause on	caused the dear							Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	5	cot	:\`C	Sho	clc				Onset and	Death
	/Medical		resulting in death)	Due to	(or as a consec				\	1			
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	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	(or as a consec	ر د	6	1		1.1	~ (°°		
_	and and Il-tran	хап	that initiated events resulting in death) Last	U	(or as a sonse		e 116	416	43	. ()			
760,	ate be executed sysicien and he burial-transit	calE		F	CULE	2	rengl	-1	tailv.	v C			
68	leath certificate attending phy I for use as the			V. —									
Box	n cert andin	N/u	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		□Ectopic pregnanc	cy			23d. Date of de Month		Year
_	ne deat the atte	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (specify)			-	WORTH	Day	1001
P.O.	that the death cer ed by the attendin detached for use	Phy	9 Unknown Part II. Other significant conditi	one contributing to c	loath but not re	culting in the	underhing cause a	ven in Part	1 23e. [oid tobacco	use contribute	to the cause of	death?
	8 5 9	Completed by Physician/Med	Tin Constitution	e \	1131	1, 10	S	TVOIT III T CALL		☐ Yes	282No 3□F	Probably 4 🗆	Unknown
Š	w requir been si should	etec	Covenas	7 0	1914	4	tire	=918	24a. \	Vas an	24b. Were a	autopsy findings	available
Rec	he lav	m d	Coverid	9	, , ,	3	12 (3)	416		utopsy erformed? es 2.20	death?		cause of
ā	nysician: The law nis certificate has b i director, page 2 sf		25. Was case referred to medical	ı I				26. Place	e of Death (Check o		40 1016	252,10	
>	Physician: this certificant	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	 ☐ ER/Outpati	ent 3 DOA	ther: 4 🗆 N	ursing Home 5 🗆 8	Residence	6 ☐ Other (Sp	ecify)	
0	ng Ph Iter th neral		27. Manner of Death	28a. Date (Moi	of Injury oth, Day Year)	28b. Time Injury	W			ibe how in	jury occurred		
Sio	Attending r death. ector: After by the funer	catle	2 ☐ Accident invest	igation				Yes 2		on (Stroot	and Number or F	Quest Doute Nue	n her
Division of Vital Records,	2 t t o c	Certification:	4 Homicide determ	ninged 200. Flat	e of Injury - At I ding, etc. <i>(Spec</i>	nome, farm, s cify)	street, factory, office)		Town, Sta		TIDIA! FICUIO FILI	11001,
	hours a unerel C	2	29a. Certifier 1 X Certifyi	ng Physician: To th	e best of my kr	nowledge, dea	ath occurred at the	time, date a	nd place, and due to	the cause	(s) and manner a	as stated.	
	HOS 124 h	edical	(Check only 2 Medica one)	Examiner: On the and ma	basis of examir nner stated.	nation and/or	investigation, in my	opinion, de	ath occurred at the ti	me, date a	and place, and du	ue to the cause((s)
	To th withir To th comp	×	29b. Signature and title of certifi	er Li				nse number		10	Date signed (Moi		
			Minn	adur.			DI	4116	. 2	N	c/cells	16,31:	2005
D	(5)		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Typ	e, Print)		- C	1	· Mi	225	7.0
			31. Date filed (Month, Day, Year	1453	Registrar's Sign	nature	12 DAL	6	SCAING	ULC	un Ini	12 508	1 4
3	St Regis	tate trar		2005	the A	* An	oute		30 ma				

			For State Registrar		State of	Maryland		artment rtificate			and Me		giene Reg. No.	05	4024	0
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	Examir		Stella Mar	is Hospic				Timo	nium	Location of	of Death		4c. Co Balti	unty of Deat	1	
late ye	Funeral Director		5. Social Security N 164-24-0127 Usual Residence of	7		Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da March 18	v. Year)	9. Birti Co Penns	nplace (State or F untry) ylvania	oreign
	Maryland a-f show	ctor	^{10a. State} Maryland	10b. County Anne Arui	ndel.	10c. City Odent	r, Town or Lo	ecation							10d. Inside City t	
	ath with the	rai Dire	10e. Street and Nu 8621 Flutte		Trail #203			10f. Zip	Code	21113			10g. Citizer	of What Co USA	untry?	
900	within 72 hours after deeth with the Maryland ane. then "natural", or itame 23e or 28e-f show to Medical Evarumer merke ricilited at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2	12. Was Decedding Armed Forcing 1 Tyes 2 If Yes, Give Year or Date	es? No		Was Deced If Yes, spec	rfy Cuba	spanic Ori n, Mexican Specify:	i, Puerto F	cify Yes or No Rican, etc.)		Race - Ame Black, White pecify: Whi	e, etc.	
21215-0036	id within 72 h giene. er then "natu	Complete	Elementary/Sec		Education grade com <i>pleted)</i> College (1-4	or 5+)	(Give	dent's Usua kind of won DO NOT us ary	k done o	urina mos	t of workin	g	16b. Kind US Sen	of Business/ ate	ndustry	
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DHMH 17 Rev 1/2001

NOVEMBER 27, 2005 12:30 a.m.

			1 - For State Registrar		State	of Marylan		irtment of F tificate of			ental	Hygie Reg.		5 40	1241
	Physic /Medi		Decedent's Nam		ALKA W.	ROBIN	NSON			,	2. Date of Month		Pay 24,	2005 3.	Time of Death 4:404 M
R	Exami	ner			on, give street and nu			4b. City, Town, o		ol Death			4c. County		
	Function		5. Social Security N		OMMUNITY H	7. Age (In yrs.	last birthday)	LAN	IHAM If Under	r 24 Hrs.	8. Date o	f Birth		E GEORG	GES (State or Foreign
	Funeral Director	2	483-36-1		1□M X F	84	Yrs.	Months Days	Hours	Min.	JAN.	, Day, Ye		Country)	
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Baltimore,	8 = 5		t ☐ Burial 2 4 ☐ Donation		3 □Removal from	State C	emetery, crem	atory or other plac		lov . 25		_			
alti	permit. Pa Departmen Important: eny Injury		21. Signature of Fu			CF		CREMATO Name and Addre AMBERS F			_	_	KIVEK	DALE, M	ш.
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/ita	Physician: The this certificate ral director, pag	Be	25. Was case refer examiner?	red to medica			/			e of Death	(Check of	nly one)			
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LO C	ding After fune	tion	1 Natural	5 Pendi	ing (Mon	of Injury oth, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2□		8d. Descr	be how in	njury occurre	ed .	
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	the Ithin 24 the Ithe Ithe Ithe Ithe Ithe Ithe Ithe	Medi	one) 29b. Signature and		and man	ner stated.		29c. License			- at 1110 (11				
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H	()		Eugene	S. C	who completed cause Raig, M	S/	1860	od Luc	KX	Poad	2 2	anh	am,	MD	20706
	Sta Registi		31. Date filed (Mon	th, Day, Year	2005	Registrar's Signat	ture	E							

			For State Registrar	State of	f Marylar		artment of F rtificate of		d Mental Hy	giene	15	40242
	Physici	an l	1. Decedent's Name (First, Middle						2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		Randy	Rid					Novembe	r 21, 2	2005	11:03 P M
	Examin	er	4a. Facility Name (If not institution Southern Mary1				4b. City, Town, o		eath		ty of Death	
_	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	Clinton If Under 1 Year	If Under 24 I		rth	9. Birth	eorge 's place (State or Foreign
	Director		086-50-6199	1 ∆ M 2□F	46	Yrs.	Months Days	Hours N	Feb. 10		Cou	oklyn. NY
	pu *		Usual Residence of Decedent 10a. State 10b. County		100 0	ty, Town or Lo	ocation					10d, Inside City Limits
	Aaryla Fehor	৳			.							1% Yes 2 □ No
	158 A	Directo	Maryland Prin	ice George	S	Dist	rict Hei	ghts		10g. Citizen o	What Cou	ntrv?
	death with the Maryland rms 23s or 28e-f ehow ricket be callified at	<u>-</u>	2626 Parkland	Drive			20747	7		United	Stat	es
	deatl	Funeral	11. Marital Status	12. Was Dece Armed Fo	ident Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin?	? (Specify Yes or No uerto Rican, etc.)			can Indian,
0000	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hyglene. If Heelth and San or 28e-f show litem 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, it a Madical Examination institut at	þ	1 Never Married 2 Marr 3 Widowed 4 Divorced	ned 1 ∐ Yes	2X No e		1 ☐ Yes 2 No	Specify:		Spec		Black
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yiand	id be ental ked o	To Be	Russell Ridley					E1	oise McCu	11ers		
	2 should be and Mental is marked aumatic ev		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street		r Rural Route Numb		n, State, Zij	o Code)
, Ma	and 2 Beith a n 27 i	ļ	Patrice Ridley	- Wife	-	2626	Farkland	Drive	District	Heights	, MD	20747
O	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 Removal from	State	cemetery, crei	nsition (Name of matory of other plac	ce)	Date	20c. Location	- City or T	own, State
baltimol	t. Pag tment tent:		4 Donation 5 Other (S	(pecify)	Mou	int Oli	vet Cemet	ery 11	/28/2005	Washin	gton,	DC
n O	permit. Pages 1 an Department of Heel Importent: If item 2 any injury or other once.		21. Sign ture of Funeral Service	TOUTO	LIV				Stewart F d, NE Was			
			23a. Part1 Er ter the dis 1 se, or shock, or heart failure. List	complications that conty one cause on e	aused the dea	th. Do not en	er the mode of dyin	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition	a			SITOCK					Onset and Death
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ה ה	execu en and rial-tra	Еха	resulting in death) Last	Due to (or as a conse	quence of):						
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J. BOX	iaw requires that the death certific es been signed by the attending p 2 should be detached for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		inth 2 ☐ Feta antattime of o	al death 3[Ectopic pregnancy Other (specify)	NA	<u> </u>		ate of deliv	ery Day Year
ŗ	w requires that the de been signed by the should be detached	Phy	Part II. Other significant condition	ons contributing to de	eath but not re	sulting in the u	ndertving cause giv	en in Part I	23e. Did	tobacco use co	ntribute to t	he cause of death?
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	w req	lete	RESPIRAL F	Airus					24a. Was	an 24b	Were auto	onsy findings available
T LE	The ate h page	Completed		-71720120					— auto	psy ormed? 2 No	prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
<u> </u>	ding Physician: After this certific	Be	25. Was case referred to medical examiner?	Hospital			Oth	05	Death (Check only			
ō	Phy rald	٦: <u>٦</u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o	npatient 2	28b. Time o	IL SLIDOA	4 🗀 Nursin	ng Home 5 ☐ Res 28d. Describe	how injury occu		(y)
<u></u>	Attending r death.	ation	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	ng (Mont	h, Day Year)	Injury		k? Yes 2 □ No				
DIVISION OF	if or Attend efter death Director:.	Certification:	3 Suicide 6 Could 4 Homicide determ	inod 286. Place	of Injury - At h	nome, farm, sti	reet, factory, office		28f. Location (City or To		ber or Rur	al Route Number,
	To the Hospital or Attenwithin 24 hours effer deatl to the Funeral Director: completely filled in by the	Medicai C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the ba and mann	asis of examina	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) and n date and place	nanner as s , and due t	stated. o the cause(s)
	To the Hc within 24 To the Fu completel	Me	29b. Signature and title of certifie				29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
2			30. Name and address of person Feltm Aud-		e of death (Ite	m 23a) (Type,			350 Fm	TWAJA	INGO	5 N,MD Y
	Sta		31. Date filed (Month, Day, Year) NOV 2 8 2	12. R							+4	7
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

NOV 2 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Red No 1. Decedent's Name (First, Middle, Last). 2. Date of Death Month 2:19AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1144 Old Field Point Road Elkton Cecil If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Min. 1 □ M 2 XF Hours 55 Pittsburgh, 169-42-0744 Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√2 Yes 2 ☐ No Maryland Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 1144 Old Field Point Road USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Advisor Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Thomas Young Martha Edna Fertiq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1144 Old Field Point Road Elkton, MD 21921 Arthur Rowlands 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 (XDonation Anatomy Gift Nov. 29,05 Hanover, MD 22. Name and Address of Facility 21. Signatur, o Fynera CC0442 see Beeson Funeral Home of Newark 2053 Pulaski Highway, Newak, DE 19702 Approximate Interval Between Onset/and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) eas an Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical **Examiner**

death certificate be executed

Box 68760.

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Records,

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To the Hospital or Attanding

death.

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Medicai

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Registrar

permit. Page Department o Important: If any injury or once. ö

Physician

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r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

filed within 72 hours after

and Mental Hygiene.

1 and 2 should be Health and Mental

Pages 1 and 2 ment of Health If itam 27

Maryland 21215-0036

Baltimore,

Examiner

burial-t physician ician/Medicai the attending esn ő the detached Physi ģ signed I 2 Completed peen has certificate Be 70 this completely filled in by the funeral Certification: After Diractor:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE:

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

24a. Was an autopsy

1 ☐ Yes 2 1 → 10 3 ☐ Probably 4 ☐ Unknown

2 3 M 26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Desidence 21010 1 🗌 Yes 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29d, Date signed (Month, Dev. Year) 29c. License number 29b. Signatūre

30. Name and address of person who completed cause of death (Item 23a) (Type MY

31. Date filed (Month, Day, Year) NOV 2 9 2005 32. Registrar's Signatur

			For Stata Registrar	State of Maryla		artment of F			ene 05 g. №. 05	40245
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Las VICTOR 4a. Facility Name (If not institution, give 200 CHARMUTH COUR	EUGENE street and number)	ROCK,	4b. City, Town, o	or Location of Deat	2. Date of Death Month NOVEMBER		
	Funeral Director		5. Social Security Number 6. Se		rs. last birthday) O Yrs.	If Under 1 Year Months Days		(Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry) nnsylvania
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. It's Mulical Examiner must be nullised at once.	To Be Completed by Funeral Director	Maryland Charles 10a. State 10b. County Maryland Charles 10e. Street and Number 200 Charmuth Cour 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Victor Eugene Roc 19a. Informant's Name/Relationship (7) Gladys J. Rock/Wi 20a. Method of Disposition 1 Serial 2 Cremation 3 County (1) 20a. Method of Disposition 1 Serial 2 Cremation 3 County (1) 21. Signature of Funeral Service Licenty	t. 12. Was Decedent Ever in Armed Forces? 1	16a. Decen (Give life.) Tra 19b. Mailin 200 C cemetery, crei rinity M	In the state of th	specify: pation during most of word ficer 18. Mother's Nar Elsie and Number or Re Court, Wi Gdns 12-(ss of Facility	me (First, Middle, M Marie Way and Houte Number, Date P.O. Box	Gb. Kind of Business U.S. Gove aiden Surname) gaman City or Town, State, cryland 20 Oc. Location - City or Waldorf, N	erican Indian, tite, etc. nite windustry rnment Zip Code) 1502 r Town, State Maryland
O. Box 68/60,	by the death certificate be executed by the attending physicien and by the attending physicien and trached for use as the burial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leaving to firmediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a const.) sequence of): sequence of): gnancy etal death 3[er the mode of dyir	~CCI	c or respiratory arres	23d. Date of de Month	Approximate Interval Between Onset and Death livery Day Year	
on of Vital Records, P	Phyaician: The law requires th: this certificate has been signed ral director, page 2 should be de	To Be Completed by	27. Manner of Death	Hasnital:	2 ☐ ER/Outpatier 28b. Time o	nt 3 DOA Oth	26. Place of Dea ier: 4 □ Nursing H y at k?	1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. Were a prior to death? 1 Yes	
DIVISION	or Attanditer death	al Certification:	2 secident investigation 3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Special control of the best of my	ecify) knowledge, deatl	eet, factory, office	Yes 2 ☐ No	City or Town,	use(s) and manner a	s stated.
	To the Hospitel within 24 hours a To the Funerel E completely filled	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier 400. Name and address of person who compared to the com	iner: On the basis of exam and manner stated.	ination and/or in	29c. Licens	pinion, death occu	irred at the time, dat	e and place, and du	e to the cause(s)
	512 Sta Registr		KRISHAN MATHUR, MI 31. Date filed (Month, Day, Year) NOV 2 9 20	32. Sigistrar's Si			WALDORF,	MD 20602		

Amend item#5, perFH, C850, 12/14/05 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death For State Registrar Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Sever14 Month 053 PAN 00 021 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Examiner 2296 Four Seasons Drive Gambrills Anne Arundel Hunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

April 6,1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2√2 F Yrs. Director 059-22-1791 77 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Gambrills Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2296 Four Seasons Drive 21054 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home and Mental Hygin permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumetic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Avery Towsley Fannie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2296 Four Seasons Drive, Gambrills, MD 21054 Gordon D. Ross, Jr. (Husband) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11-23-2005 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Kidgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Irterio Sclerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Whiknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 21306 Division of Vital 1 Yes Hospitel or Attending Physicien: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) Depitty 29d. Date signed (Month, Day, Year) D000605 use of death (Item 23a) (Type, Print) JONES; MA Registrar's Signature 31. Date filed (Mon State 28 Registrar

O5-07976 Timika Revels

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ULLF	ta keve	TD	_ For		State of Marylan	id / Departme	ent of Health and	Mental H	ygiene		10017
			1 = State Registrar			Certifica	ate of Death		Reg. No	CUU	40247
п	Physici	an	1. Decedent's Name (First, Mi	ddle, Last)	1 65	Di	TVELS	2. Date of D Month	Day		3. Time of Death
	/Media	cal	4a. Facility Name (If not institu	tion aives	treet and number)	4b. G	EYELS ity, Town, or Location of Dea	Novemb		6, 2005 County of Death	12:39 p ^M
1	Examir	ier			l Medical Cen		alisbury			Wicomico	
	Funeral		5. Social Security Number	6. Sex		last birthday) If Un	der 1 Year If Under 24 Hr	s. 8. Date of B			aplace (State or Foreign intry)
	Director		Usual Residence of Decedent	7	30	Yrs.		10-1	- 7	5	NiVi
	yland		10a. State 10b. Cou		10c. Cit	y, Town or Location					10d. Inside City Limits
	Pe-1 st	ctor	Md W	DYCE	ester to	comok	e CitY				Yes 2□No
	with th	Funeral Director	10e. Street and Number	, -	1 1	10f.	Zip Code		10g. Citi	izen of What Cou	untry?
	ns 23	eral	11. Marital Status	h) -	TEET 12. Was Decedent Ever in U	.S. 13. Was De	cedent of Hispanic Origin? (Specify Yes or N	lo-	14. Race - Amer	ican Indian,
9	or Ite	Fur	Never Married 2 N	Married	Armed Forces? 1 Yes 2 No If Yes, Give		pecify Cuban, Mexican, Pue 2 No Specify:	erto Rican, etc.)		Black, White	, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show he Madical Exemirar must be notified at	d by	3 Widowed 4 Divor		Year or Dates:		* -		105 10	Specify.	
5	n na	plete	(Specify only high		completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of w Tuse retired)	orking	16b. Ki	nd of Business/I	ndustry
212	filed with Hygiene other thai	Completed	Elementary/Secondary (0-1	۷)	College (1-4or 5+)	CNA	ssistant		NU	IRSing	
Maryland	be file	Be	17. Father's Name (First, Mide	lle, Last)		1	0	ame (First, Middl	e, Maiden	Sumame)	
Z	2 should t and Ment Is marked	70	19a. Informant's Name/Relati	onship (Tva	oreman		ess (Street and Number or F		ber. City o	Town State Z	n Codel
Z	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Ifem 27 Is marked other than "natural", or Items 23a or 28e-1 show then traumatic event, the Madical Exeminar mast be notified at		0 10	reis,	/mother	1	HSt. Pocono				
ore,	00		20a. Method of Disposition 1 ■ Burial 2 □ Cremati	7	20b. F	Place of Disposition (i	Name of place)	Date	20c. Lc	cation - City or T	own, State
Baltimore	Part and Par		□Donathen 5 □Othe	(Specify)	IM+	Sinai Chu	ch Cem. 12.	3-05	Poc.	mile (1ty, Md
Bal	permit. Departr Importa any inju	1	21. Signature of Funeral Serv	ice License	P/	22. Name	and Address of Facility				Ke, Md aresi
			23a. Part1. Enter the disease shock, or heart failure.	or complic	ations that caused the deat	h. Do not enter the n	node of dying, such as cardi	ac or respiratory	arrest,	1,100014	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	zieromy on	SMOKE A		· INITALIST	-1170			Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a conseq		(1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	7.0			
		er	Sequentially list conditions, I any, leading to immodate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a consec	wanta of):					
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,092	te be executed ysicien and ne burial-transit		resulting in death) Last		Due to (or as a conseq	uence of):					
687	# ₹ B	dicai		d							
Box (leath certifical attending phy if for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outcome of pregna					23d. Date of deliv	rery
	The law requires thet the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		1☐Live birth 2☐Feta 4☐Pregnant at time of d 9☐Unknown		c pregnancy (specify)			Month	Day Year
P.0	thet the de ed by the detached	Phy	9 Unknown Part II. Other significant con-	ditions con	tributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Records,	uires l	d by					g 52555 g.v.s	11:			bably 4 Dunknown
00	aw requir s been si 2 should	Completed						24a. Wa	s an	24b. Were aut	opsy findings available
_		Com						per 1 Yes	opsy formed? 2 \(\square\) No	death?	ompletion of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to med examiner?	-				eath (Check only	опе)		11.2
o	Phys this ral dir	T.	TXYes 2 □ No 27. Manner of Death		ospital: 1 ☐ Inpatient 2X 28a. Date of Injury	ER/Outpatient 3 28b. Time of		Home 5 ☐ Res			fy)
on	Attending I r death. ector: After by the funer	ation	1 □Natural 5 □ Pe	nding estigation	(Month, Day Year)	Injury	28c. Injury at Work?		•		5 121 123
Division	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fac	tory, office	28f. Location		d Number or Rui	al Route Number,
Ö	itel or A				Ati	10 ME		7025	msr	POCOMON	
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier 1 Certi (Check only 2 Medi one)	fying Phys cal Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurr tion and/or investigat	ed at the time, date and plaction, in my opinion, death occ	ce, and due to the curred at the time	e cause(s) , date and	and manner as : place, and due !	stated. to the cause(s)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Me	29b. Signature and title of cer	tifier	0		29c. License number		29d. Dat	e signed (Month,	Day, Year)
			Morant		me Knul	in	O.C.M.E.		Nove	ember 27	, 2005
			30. Name and address of per-	on who co	mpleted cause of death (Iter		Ct D	1.:			
	Sta	te	31. Date filed (Month, Day, Y	ear)	32. registrar's Signa		nn Street, Ba	1TC1more	, Mar	yrand 2	IZUI
	Registi		NOV 3		05 Steers	to specific					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1615 M BARBARA ANN RUTKOWSKI /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Wiconico giorn/ medical Center Keninsula Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 2**X**F Days Hours Min. 68 Yrs. DEC. 10, 1936 MARYLAND 219-32-4917 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other then "naturel", or items 23s or 28s-1 show other treumstic event, the Mudical Examinar must be notified at 1X Yes 2 No Director MARYLAND WORCESTER OCEAN CITY 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 131A CAPTAINS QUARTERS 21842 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BANKING 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be Pages 1 end 2 should be item 27 ie marked c WALTER DEAL MARTE MIXTURE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOSEPH ROBERT RUTKOWSKI/Husband 131A CAPTAINS QUARTERS, OCEAN CITY, MD 21842 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages i Depirtment of h Important: if its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 11/30/05 DELMAR, DELAWARE 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhage **Physician** Arachoroid /Medical Due to (or as a consequence of). Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to i as a consequence of) Physician/Medical Examiner sicien and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, phys. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a detached f 9 Uaknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 | Yes 2 1 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 2□ No certificate 2 1 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manual of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Tes 2 No death 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge death conurred at the time, date and place, and due to the causa(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) Medical 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 10041211 ale, und 30. Name and address of person who simpleted cause of death (Item 23a) (Type, Print) 100 E. Calloll Acle, ernando 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Miriam 3 Vember 26, 2005 2112 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner medical Cente EDIASULA LEGIONAL WICOMICO Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number **Funeral** Days Hours 1□M 2**K**F 95 230-34-6679 Director 2/10/1910 Maryland Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other then "natural", or items 23a or 28a-f ehow traumatic event, <u>tre Modical Examinar must be notitied at</u> 1 ☐ Yes 2 No Ocean Pines Director Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1135 Ocean Parkway 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes ZM No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: Specify: white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Owner Clothing Apparel 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Hackerman Harry Potts 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10706 Piney Island Dr., Bishopville, MD 21813 Hal Glick/son item 2 20b. Ptace of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite eny injury or ot ance. Beth Tfillon Jewish 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/05 Baltimore, MD Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liven ee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) homorrhag Physician Introcerobral /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine physiclen and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the eld be deteched for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Mellitis Tym 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 3 No After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Thomicide within 24 hours after To the Funeral Discompletely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dise to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and/fittle of certifier

Registrar DHMH 17 Rev 1/2001

State

55# 230-34-467

1104

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Drine

Henlthway

11/27/05

21807

MI

M.D.

32. Angistrar's Signature,

Caller

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

Anoia

Janes 31. Date tiled (Month, Pay, Year) 9 2005

05-7817 TIFFA	NY SIMMONS-GLASS	at in Black Indelible ink. Engure Al	I Coning Ave I agible
UNKNOWN 05-78	State of M	nt in Black Indelible Ink. Ensure Al aryland / Department of Health and M	
	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death
Physician /Medical	Tiffany Simmons-Glass		NOV. 19. 2005 2305 P
Examiner	4a. Facility Name (If not institution, give street and number) NORTHBOUND 9823 PISCATAWAY	ROAD 4b. City, Town, or Location of Death CLINION	4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 579 02 7689 Usual Residence of Decedent	40 Yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Oct. 2, 1965 Washington, DC
with the Maryland t or 288-1 show be notified at	10a. State 10b. County MD Prince Georges	10c. City, Town or Location Clinton	10d. Inside City Limits 1 ⊠ Yes 2 □ No
th with the 23a or 28 and 10 a	3302 Strawberry Hill Drive	10f. Zip Code 20772	10g. Cilizen of What Country? United States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, it a Mudicul Examination and the page. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 2 □ Married 1 □ Yes 3 □ Married 1 □ Married 1 □ Married 1 □ Married 1 □ Married	If Yes, specify Cuban, Mexican, Puerto	ncify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036 Deartin: Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Mporfent: If Item 27 is marked other than "natural", or nny injury or other traumatic event, it a Mudicul Exart ance. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of works) ife. DO NOT use retired) Medical Receptionist	ng 16b. Kind of Business/Industry Private Industry
/land wild be file Mental Hy whice oth atic event	17. Father's Name (First, Middle, Last) William Arthur Simmons		(First, Middle, Maiden Sumame) Ann Garvin
Mary 12 shound and No.	19a. Informant's Name/Relationship (Type, Print) Delores A. Simmons / Mothe	19b. Mailing Address (Street and Number or Rura r 5802 New Hampshire Ave.	
imore, I Pages 1 and ment of Heatil	20a. Method of Disposition 1	20b. Place of Disposition (Name of cometery, crematory or other place) Maryland Veterans 11/2	20c. Location - City or Town, State 9/2005 Cheltenham, Maryland
Balt permit. Departi	21. Signifure of Funeral Service Licenshe	22. Name and Address of Facility Joh 3015 12th Street, N	n T. Rhines Funeral Home E Washington, DC 20017
Physician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	d the death. Do not enter the mode of dying, such as cardiac one. De increes a consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death
68760, ifficate be executed g physician and as the burial-transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	
Box ath cert ttendin or use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
rds, P.O. I	Part II. Other significant conditions contributing to death t	out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, to attending Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by	25. Was case referred to medical		24a. Was an autopsy performed? 1 XYes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 XYes 2 □ No
of Vital Physicien: rthis certifica ral director, TO BE C	examiner? 1 XYes 2 ☐ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 6 (XOther (Specify) AT SCENE
Division C To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera Medical Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of In building, e	05 23:02 M 1□Yes 2 XNo	28d. Describe how injunt occurred Liver of motor vehicle Linich Struck fixed object 28d. Location (Street and Number or Rural Route Number, N. Or Town, State 1823 Piscatura, Road
Diversities or Hospitel or Paneral Dir Funeral Dir Italied in Italied in Italical Cert	29a. Certifier 1☐ Certifying Physician: To the best	of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.
the Hosp thin 24 hour the Fune impletely fill	one) 21x Medical Examiner: On the basis of and manner st	of examination and/or investigation, in my opinion, death occurrated. 29c. License number	ed at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
To To Conn	Hota (his =	O.C.M.E	NOV. 20, 2005
CR Og		death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORI	E,MARYLAND 21201
State Registrar	31. Date filed (Month, Day, Yeàr) NOV 2 9 2085	rar's Signature	

ORIGINAL

			1 - For State Registrar	tate of Marylar	nd / Depa <i>Cei</i>	artment of H <i>tificate of L</i>	lealth and N Death		jieme 05	40251			
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Yea	3. Time of Death			
	Physici /Medic		DAVID EUGENE SLYE,	SR.				Novembe	r 25, 200				
	Examin	er	4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Death		4c. County of De				
			6406 Old Sandy Spri		In ma to instruction of	Laurel If Under 1 Year	If Under 24 Hrs.	1.0		George's			
	Funeral Director		5. Social Security Number 6. Sex 1 № M	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	1001	Birthplace (State or Foreign Country)			
			Usual Residence of Decedent	74				June 2,	1931 Ma	ryland			
	yland		10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits			
	e Ma	ctor	Maryland Prince Geo	rge's La	urel					1 □ Yes 2 No			
	ith th or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?			
	eth w		6406 Old Sandy Spri			20707			U.S.A.				
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28e-f ehow eumatic event, it e Medical Examiner must be notilled at	by Funeral	1 ☐ Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 Yes - 2 M No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cubai □ Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: To				
ğ	2 hou	Completed	15. Decedent's Education	on	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busines	ss/Industry			
215	thin 7 e. an "n Med	ple	(Specify only highest grade co	mpleted) Coltege (1-4or 5+)	life. L	kind of work done o OO NOT use retired,	furing most of work)	ring	Christian	Life			
2	ygien ygien ser th	Con	12		Minis	ster			Center, I	nc.			
p	tal Hid oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumame)				
3	should band Ment s marked umatic	10	Benny M. Slye 19a. Informant's Name/Relationship (Type,	Delant	101 11 11	1	Stella l						
<u>a</u>	d 2 st th and 7 is r treur		Brenda G. Slye - Wi	•					City or Town, State	ryland 20707			
ව	Heel Heel tem 2		20a. Method of Disposition			sition (Name of natory or other place			20c. Location - City				
ē	Pages ent of ht: If i		1 N Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	Valificiti State		oln Cemeter	1	8/2005	Brantwood	, Maryland			
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Importent: If item 27 is marked any Injury or other treumatic ex SDCs.		21. Signature of Juneral Service Licensee	1.0	22	. Name and Addres	s of Facility Gas	sch's Fu	neral Home	e, P.A.			
	40260		23a Part 1 Enter the disease or complication	ons that caused the dea					sville, M	Approximate			
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition List only one cause on each line. Interval Between Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset										
	/Medical		resulting in death)	Due to (or as a consec									
	Examiner	_	Sequentially list conditions, b	Due to (or as a consec	trophic	lateral	5 Clero	573					
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a compsec	quence or):								
<u> </u>	ificate be executed g physician and as the burial-transit	Examiner	resulting in death) Last	Due to (or as a consec	quence of):								
68760,	te be ysicia ie bur	edical	d										
	ntifica ng ph as th		IF FFMALE.										
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?	If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	al déath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year			
	that the the the the the the the the the th	y Ph	Part II. Other significant conditions contrib	uting to death but not res	sulting in the un	iderlying cause give	n in Part I.	23e. Did tob	pacco use contribute	to the cause of death?			
ords	v requires that the de been signed by the should be detached	ted by						1 □ Y€	es 2 □ No 3 □ I	Probably 4 X Unknown			
Records,	hyelcien: The law ra nis certificate has be I director, page 2 sh	Completed						24a. Was ar autops perform 1 \sum Yes 2	y prior to ned? death?	autopsy findings available completion of cause of			
Vita		BeC	25. Was case referred to medical examiner?				26. Place of Deat			2 110			
	Physics this ce al dire	To	1 Yes 2 X No Hosp	ital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Dthe	4 Nursing Ho	me 5 ∏ Reside	ence 6 Other (Sp	ecify)			
ouo	nding Ph ith. :: After th e funeral		27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 □ No	28d. Describe ho	ow injury occurred				
Division of	ne Hospital or Attending Phyelcien: n 24 hours efter death. he Funerel Director: After this certific pletely tilled in by the funeral director,	Certification;	a Deviside 6 D Could not be -	8e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number or I i, State)	Rural Route Number,			
		Medical C	29a. Certifier (Check only one) 1 Certifying Physicie 2 Medical Exeminer:	on: To the best of my kno On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	25	9d. Date signed (Mo	nth, Day, Year)			
			1 Kon OX	~		DOD	38291	1	November 2	8, 2005			
	(10)		30. Name and address of person who compl	eted cause of death (Iter	m 23a) (Type, I			1					
			Jeffrey D. Rothstein	n, M.D., Ph						21287-5953			
	Sta Registr	- 4	31. Date filed (Month, Day, Year) NOV 2 9 2005	2. Registrar's Signa		E)							

State of Maryland / Department of Health and Mental Hygiene 🕦 5 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** NOVEMBER 20, 2005 2:45P M VIOLA ESTELLE STATON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CRESCENT CITIES NURSING CENTER RIVERDALE PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 - M 20XF Months Director 80 DEC. 22,1924 NORTH CAROLINA 578 22 1418 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other then "natural", or items 23s or 28a-f show other treumatic event, If a Medical Examiner must be inclined at XX Yes 2 No Directo RIVERDALE MARYLAND PRINCE GEORGES 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code with UNITED STATES 20737 death 4409 EAST WEST HIGHWAY Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iter any injury or other treumatic event, Ira Madical Examinal ODGS. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK þ XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE DOMESTIC 12TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JESSIE PITT GERTRUDE GORHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMMA ALEXANDER / DAUGHTER 500 PICKWICK VILLAGE WAY SILVER SPRING, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESSURECTION CEMETERY 28 NOV 2005 CLINTON, MD 21. Signature of Funeral Service 22. MARSHALL STFUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXVunknown ALZHEIMER'S DISEASE Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes XX No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes XX No 2 er death. rector: After this by the funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; XXNatural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a 🚻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D01852 NOVEMBER 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HYATTSVILLE, MD 20781 4203 QUEENSBURY ROAD PAUL A. DeVORE, M.D. 31. Date filed (Month, Day, Year, 2. Registrar's Signature. State Registrar NOV 2 8 2005

State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Year Nov. 2005 2:33a Kevin Edward Staton 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges General Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**] M 2□ F Days Hours Director 212-64-2559 51 12/31/53 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner neet by notified at 1 X Yes 2 No Director MD P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ត់ 238 5803 Folgate Ct. 20743 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 5 1 ☐ Yes 2 ☐ No ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Custodial P.G. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Zelmon Staton unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trai once. 5803 Folgate Ct.Cap. Hgts.Md.20743 Marjorie R. Staton/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem 11/26/05 Brentwood MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licenses 3910 Silver Hill RD.Suitland.Md.20746 enuce 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricular Fibrillation Physician Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Pulmonic Valvulaplasty 4yrs Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit Essential Hypertension 4yrs and resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death the t 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown signed by the ۵. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Vitamin Deficiency 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes of Vital Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Tes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 2√ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Division 1 ⊠Natural death. 1 ☐ Yes 2 ☐ No 2 Accident al or Attend after death Director: filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1100 mercantile LN # 135 Largo, Md 20774 mo 31. Date filed (Month, Day, Year) State NOV 2 8 2005 Registrar

			For Stete Registrar	State of	of Maryla		artment of rtificate of		nd Mental H	ygieņe Reg. No		40254
			Decedent's Name (First, Middle)	Last)					2. Date of D	eath		3. Time of Death
	Physicia	_	Calvin	E	٠.	Sava	ge		Nov. 2	6, 20	y Year 005	16:45 p ^M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town,	or Location of			. County of Dea	th
			Sunbridge Care	& Rehab			Elktor	ı			Cecil	
	Funeral			6. Sex		rs. last birthday)	If Under 1 Yea Months Days		Min. (Month, L	lirth Day, Year)	9. Bir	thplace (State or Foreign
ш	Director		222-10-7345	1 X M 2□F	84	1 Yrs.			Jul. 2	6,192	21 Wilm	nington, DE
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits
	Aaryii r sho	5		actlo		Newark						1 Yes 2 No
	28e-i	Director	Delaware New C	astre		MEMOTIV	10f. Zip Code	,		10g Cit	tizen of What Co	auntry?
	with Baor	<u>=</u>					19702				SA	, or in y .
	leath	era	14 Lyric Drive	12. Was Dec	edent Ever in	1 U.S. 13.	1	Hispanic Origi	in? (Specify Yes or N		14. Race - Ame	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23s or 28e-f show any injury or other treumatic event, Ite Madical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed F	orces? 2∭No ive		f Yes, specify Cu 1 ☐ Yes 2🂢 N	ban, Mexican,	Puerto Rican, etc.)		Black, White	-
ŏ	2 hou	ed d	15. Decedent			16a. Dece	dent's Usual Occ	upation		16b. K	(ind of Business	/Industry
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2	d with	E O	12	4	1-401 54)	Acc	ountant			Inc	dustrial	L
ק	e file al Hy othe vent,	Bec	17. Father's Name (First, Middle, L	ast)				18. Mother	s Name (First, Midd	le, Maiden	Sumame)	
<u>Jai</u>	Venta Venta rrked	2	Frank G. Savag	е				Cora	Owen Rho	ads		
an	and has me		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Stree	et and Number	or Rural Route Num	ber, City o	or Town, State, I	Zip Code)
Σ	and 2 salth n 27 i		Carol R. Zerva	S				ve, New	ark, DE 1	9702		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	3 □Removal from	ł.	o. Place of Dispo cemetery, crei	sition (Name of natory or other p	ace)	Date	20c. L	ocation - City or	Town, State
Ĕ	Pag nent ent: f ury o		4 □ Donation 5 □ Other (Sp			R. W. H	erris	N e	ov. 28,0	5 We	est Che	ester, PA
Baltimore, Maryland 21215-0036	Departimport any inj		21. Signature of Funeral Service	000	142	Be	Name and Add	neral H	Newark,	wark	19702	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the de	eath. Do not ent	er the mode of d	ring, such as ca	ardiac or respiratory	arrest,	19102	Approximate Interval Between
	Physician		Immediate Cause (Final	only one cause g	rds ta		20					Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	(or as a cons	1	,, ,					
	Examiner				61 61	eed.						
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ó	exection and the section and t	EX	resulting in death) Last	Due to	(or as a cons	sequence of):						
8760,	icate be executed physicien and s the burial-transit	dlcal		d								
9	rtifica ng ph as th		IE EENAL E									
.O. Box	thet the death certificated by the attending properties as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2□F nant at time o	etal death 3	Ectopic pregnan Other (specify)	су			23d. Date of dei Month	livery Day Year
<u>α</u>	The law requires thet the site has been signed by the page 2 should be detached.	H.	Part It. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause o	iven in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
ds,	uires sign								10	Yes 2	.□No 3	robably 4 Dunknown
Records,	w requir been si should	Completed							24a. Ws	is an	24b. Were au	utopsy findings available
Re	The tay cate has page 2	m							— aut	opsy tormed?	prior to death?	completion of cause of
Vital		e Cc	25. Was case referred to medical					36 Place	1 ☐ Yes of Death (Check only		1 ☐ Yes	2 No
S		To B	examiner?	Hospital:	Inpatient 2	2 ☐ ER/Outpatier	nt 3 DOA	thos .	sing Home 5 Re		6 ∏Other (Spe	ciful
of	Phys er this eral di		27. Manner of Death	28a. Date	of Injury	28b. Time o	28c. Inj	ury at	28d. Describe			ony,
Division	Attending Ir death. ector: After by the fune	atlo	1 Accident 5 Pending	1	nth, Day Year	r) Injury		ork? ⊒Yes 2.⊟N	0			
VIS.	Atter r dea ector by the	ifica	3 Suicide 6 Could r	ned 286. Plac	e of Injury - A	t home, farm, sti	eet, factory, offic	Ð				ural Route Number,
Ö	s efte	Certification:	4 Homicide	Dulk	ling, etc. (Spe	<i>вспу)</i>			City of 1	own, State	θ)	
	To the Hospitel or Attending I within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 1 Certifyin 2 Medical (xaminer: On the	pasis of exam	tination and/or in	vestigation in my	opinion death	place, and due to the cocurred at the time	a date and	d place, and due	a to the cause(s)
}	To the within 2 To the complet	Me	29b. Signature are title of certified	N.	\bigcirc		29c. Lice	0063	3720 Str 3B	29d. Da	ge signed (Mont	h, Day, Year)
	1 .		30. Name and address of persent	who completed cau	se of death (ttem 23a) (Type,	Print)		74 70	C	1/10	00 1/01/
	9		Virani Ava	ni, M	0 118	8 NOT	1th 87 1	eet s	STO 3B	611	knon m	11) 2174
	Sta		31. Date filed (Month, Day, Year)	OV 2 0 2	Registrar's Si	Mature	H dos	de				
	Registr	2	11/50/02	N 9 L	JUJ /							

	ĺ	For State Registrar	State of	Marylan	•	rtment o			ental Hyg	iene 05	40255
Physicia	an	1. Decedent's Name (First, Middle							2. Date of Deat Month	Day Yea	
/Medic	al	Donald Kennet			RSING	4h City Toy	wn, or Location		NOVEMS	4c. County of De	
Examin	er	BROOKE GROVE REA		•			_	PRING	r	MONTG	
Funeral		5. Social Security Number		7. Age (In yrs. I	last birthday)	If Under 1 Y	ear If Und		8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
Director		577-36-5383 Usual Residence of Decedent	PE IN 201	79	Yrs.				Oct. 25	, 1926 R	Rhode Island
yland how		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
Ne Mar	ctor		gomery	Re	ockvil						1 ☐ Yes 2 ☑ No
with the a or 2	Funeral Director	10e. Street and Number 15325 Carrolton	n Dood			10f. Zip Co 2085			'	0g. Citizen of What	Country?
death ms 23	nera	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. V			Origin? (Spec	cify Yes or No- Rican, etc.)	14. Race - Ar	merican Indian,
or Ite	Ful	1 Never Married 2 X Marr	If Yes, Giv	2 🗆 No e		r res, specily I□ Yes 21⊡			nican, etc.)	Black, W Specify: W	
If E. 12.10.000. Itied within 72 hours after death with the Maryland Hygiene. Hygiene. The "naturel", or Items 23a or 28e-f show the than "naturel", or Items 23a or 28e-f show ant, the Medical Examinating and the model of a natural parameters.	ed by	3 Widowed 4 Divorced	Year or Da	ates: 1945-		ient's Usual O	ccupation			16b. Kind of Busines	
nin 72	Completed	(Specify only highest Elementary/Secondary (0-12)		-4or 5+)	(Give	kind of work a DO NOT use r	tone during m	nost of workin	g		
ad with giene er tha	Com		4	-401 547	Ana	alyst				Agen	Intelligence
yidilia 2.12 build be filed with Mental Hygiene arked other that atic event, the	Be	17. Father's Name (First, Middle, Harold Sulliv					18. Mo			Maiden Sumame)	
2 should be and Mental Is marked of sumatic every	ရ	19a. Informant's Name/Relations			19b. Mailin	ng Address (Si	treet and Nun		n Duffy Route Number	; City or Town, State	e, Zip Code)
and 2 s and 2 s ealth an m 27 ls ner trau		Constance T. S		Vife	1533	25 Carı	rolton	Road,	Rockvi	lle, MD 2	0853
of He a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	,	20b. P	lace of Dispo- emetery, cren	sition (Name of natory or other	of r place)	Nov.		20c. Location - City	or Town, State
Pages tment of the tent: If its		'4 ☐ Donation 5 ☐ Other (S	oecify)	Gat	e of He			200	5 <u>s</u>		ing, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature Funeral Service	Licensee A	6-						Home Inc lver Spri	ng, MD 20901
		23a. Part1, Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	eused the deatl	h. Do not ente	er the mode o	f dying, such	as cardiac or	r respiratory arre	est,	Approximate Interval Between
Priysician		Immediate Cause (Final disease or condition	•	PATIC	N P	NEUN	1000	A			Onset and Death DAYS
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
	ē	Sequentially list conditions,		PHAG or as a cons							WEEKS
ansit	Examin	that initiated events	.VAS	or as a conseq	DE	MEN	AFTC				YEARS
or ou, sate be executed bhysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a conseq	uence of):						'
I MECCINS, P.O. BOX 00100, The law requires that the death certificate be executed tale has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical		d								
w requires that the death certificate signed by the attending place of signed by the attending place of signed by the attending place of signed by the attending place of signed by the attending place of signed by the signed signed by the signed signed by the signed signed by the signed si	υ/Mec	IF FEMALE: 23b. Was decedent pregnant		come of pregna		1 =				23d. Date of	delivery
death death ne atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No		irth 2 ☐ Feta ant at time of d own		Ectopic pregr Other (speci				Month	Day Year
nat the d by ti		9 ☐ Unknown Part II. Other significant conditie			ulting in the u	nderlying caus	se given in Pa	art I.	23e. Did to	bacco use contribute	e to the cause of death?
dires the signer of the control of t	d by	Tarrit. Guid. Significant			,				1 □ Ye	es 2 □ No 3 □	Probably 4 Munknown
law requires as been sign	oleted								24a. Was a	n 24b. Were	autopsy findings available to completion of cause of
VICAL MEC sicien: The law s certificate has t lirector, page 2 s	Compl								autops perform	med? death	res 2 No
ysicien:] ysicien:] is certifical director, p	Be C	25. Was case referred to medica examiner?	Hospital:						(Check only on		
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ION nding tth. r: Afte e fune	ation	1 Natural 5 Pendir 2 Accident investi	9	of Injury th, Day Yeer)	Injury	М	Work? 1 ☐ Yes 2	! □ No			
OIVISION or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	icod 286. Place	of Injury - At he	ome, farm, str	eet, factory, o	ffice	2	Bf. Location (St City or Town		Rural Route Number,
Ditel o		200 Continue 19 Continue	ng Physicien: To the	best of mules	nuisdes dosti	b occurred at t	the time, date	and place a	and due to the c	auso(s) and manner	as stated
UNISION OI VIIA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	edical	/Check only 2 Medical	Exeminer: On the h	asis of examina	tion and/or in	vestigation, in	my opinion.	death occurre	ed at the time, d	late and place, and c	due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifie	r			29c. L	icense numb	er	2	9d. Date signed (Mo	onth, Day, Year)
121		mes	STAFF PH	HYSICIA	4~	D	420	46	N	WEMBER	25, 2005
1-		30. Name and address of person	who completed caus	se of death (Iter	п 23а) (Туре,	Print)	Page (Ann.C	00 Ni= N	VACIA	12 000/00
St	ate	30. Name and address of person GRACE BROOKE HE 31. Date filed (Month, Day, Year)	32. F	gistrar's Signa	ature	Server)	MAD 7	711-47	110114	Y INCY CAL	13 20 860
Regist	rar	NOV 2	9 2005	Barre .	15 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 22, BETTY J. SMTTH NOV. 2005 10:30 A^M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BEL PRE NURSING HOME MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 8. (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M Yrs Director 579-38-2205 75 WASH. MARCH 17,1930 D.C. Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner roust be notified at 1 Yes 2 No Director PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 908 NOVA AVE. 20743 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married ö 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 'natural', Completed the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working (life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 SALES CLOTHING other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Ie marked o ို THOMAS WHARTON LENA LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SMITH/SON 26th ST., CHESAPEAKE BEACH, MD. 20732 THOMAS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State injury or * 4 ☐ Donation 5 ☐ Other (Specify) EBENEZER CHURCH CEM. 12-5-2005 ROUND HILL, VA. 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. any M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIOPULMONARY FAILURE /Medical Due to (or as a consequence of) Examiner CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed ATRIAL FIBRILLATION burial-tran and Due to (or as a consequence of) physician Physician/Medical as the attending esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Į Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown څ signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires p FAILURE TO THRIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Thunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? STROKE, RT. HEMIPLAGIA 24a. Was an has page 2 certificate 1 ☐ Yes 2 ☐ No DEPRESSION 1 Yes 2 **X**No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: After Hospital or Attending 5 Pending investigation XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident in by the the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide hours after pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

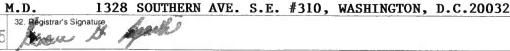
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 54 the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D51520 NOV. 25, 2005

State Registrar 31. Date tiled (Month, Day, Year) 2 9

BAHRAM

PISHDAD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Box 68760,

o

₫.

Records,

Division of Vital

Birthplace (State or Foreign Country)

Wash.

6:00 P M

D.C.

10d. Inside City Limits 1K Yes 2 No

Approximate Interval Between Onset and Death

months

Year

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Reg. No.

State Registrar

31. Date filed (Month, Day, Year)

NOV 29

2005

ORIGINAL

6		Tor State Registrar	State of Marylan		artment o				giene Rog. No.	05	40258
Physici		1. Decedent's Name (First, Middle, La	SCHMIPT					2. Date of Dea	Day	Year 200	3. Time of Death
/Medio Examir	. 4	4a. Facility Name (If not institution, give			4b. City, To		ation of Death		4c. C	ounty of Dea	-
Funeral Director		5. Social Security Number 245–30–2566 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 ☐ M 2 🛱 F 81	ast birthday) Yrs.	If Under 1 Months		Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Day Sept. 2	v, Year)	C	thplace (State or Foreign buntry) rth Carolina
Aaryland show	ō	10a. State 10b. County		,Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ ♦ 10
th the Nor 28a-	Director	10e. Street and Number	Tallact 11		10f. Zip Co	ode		-	10g. Citize	n of What Co	
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is marked other then "natural, or items 23e or 28e-f show or other traumatic event, the Mudical Examinar matters in items or items or items and items or items.	by Funeral	813 Cedar Croft 11. Marital Status 1 Never Married XXMarried 3 Wildowed 4 Divorced	Drive 12. Was Decedent Ever in U. Armed Forces? 1			Cuban, Me	ic Origin? (Sp exican, Puerto ecify:	pecify Yes or No- p Rican, etc.)	. 14	Black, Whi	orican Indian, e, etc. hite
within 72 h ane. then "netu	Completed	15. Decedent's E (Specify only highest grants) (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give life.	dent's Usual (kind of work (DO NOT use) maker	done during	g most of wor	king		of Business	,
lary lattic A. I.Z. I.Z. Should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event	To Be Co	17. Father's Name (First, Middle, Last William Maston M		поше	шакег			ne <i>(First, Middl</i> e, ee Marti	Maiden St	√n Hom umame)	e
Ma d 2 d 2 d 1 d 1 d 1		19a. Informant's Name/Relationship (Gilbert L. Schmi	• •			Street and N	lumber or Ru	nal Route Numbe	r, City or 1		
Dallinore, permit. Pages 1 an Deperment of Heat important: if item 2 any injury or other once.		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	emetery, crer	sition (Name matory or othe Memori	er place)	11-3	0-2005		tion - City or	Town, State 1e, MD
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Physician /Medical Examiner		23a. Part1. Enter the disease, of conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	applications that caused the death one cause on each line. a. Due to (or as a consequence)	TINI	er the mode o						Approximate Interval Between Onset and Death 2 Months
13%	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	,							
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w requires that been signed by should be detailed.	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying caus	se given in	Part I.		bacco use		the cause of death?
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vician: 1 /sician: 1 s certifical	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	Hospital:	ER/Outpatier	* 3 \ DOA			th (Check only one 5 Resid		70th (0	- £ .)
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe h			спу)
UNISION Ital or Attending Ital or Attending Its after death al Director: Afte	Certification:	3 Suicide 6 Could not to determined		ome, farm, str	eet, factory, o	office		28f. Location (S City or Tow		lumber or Ri	ıral Route Number,
the Hosp in 24 hou the Funer pletely fill	ledical	29a. Certifier 1 ★Certifying Pl (Check only one) 2 ★ Medical Exa	hysicien: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at vestigation, in	the time, da i my opinior	ate and place, n, death occur	and due to the orred at the time, o	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)
To I To I	W	29b. Signature and title of certifier	it4. M.D		29c. L	icense nun	hber 4 34		VOI	igned (Mont	h, Day, Year)
		30. Name and address of person who		23a) (Type, PAVL	Print) PLAC	E E	BACTI	nine.	a10	212	02
Sta Regist		31. Date filed (Month, Day, Year) NOV 28	32. Registrar's Signa	ture	houle	,					

			1 - For State Registrar	State of I	Marylar			nt of H		and M	_	giene) ()5	4025	9
	Physici		Decedent's Name (First, Middle, L Anne	.ast)	Sa	abeno					2. Date of Da Month Novemb	Day	Year 2005	3. Time of De 8:30 a	
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. Cit	y, Town, or	Location of	of Death	110 / 01110	- T	ty of Death		
			Heritage Harbou				1.	napoli		0.4.1			Aru		
	Funeral Director		104-18-0222	Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs.	last birthday) Yrs.	Month	er 1 Year s Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sept.	th 19, Year) 7, 1914	9. Birth Cou Nev	place (State or Fo intry) V York	reign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City L	imits
	Mary I-f eh	ţō	MD Queen	Annes	Qı	ieensto	wn							1 ☐ Yes 2 [χNo
	th the	Jirec	10e. Street and Number				10f. 2	Zip Code	-			10g. Citizen o	What Cou	ntry?	
	ath w	rait	820 Stagwell Ro	7					658				JSA		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow may injury or other traumatic event, The Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1	ss? XX No	+		edent of Hi becify Cuba 2 No	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	Spec	ace - Amen ack, White, ify:		
200	72 ho	Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Us	sual Occupa work done d	ation	t of works	20	16b. Kind ol	Business/Ir	ndustry	
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22	illed w Hygie ther ti nf, ib		10 17. Father's Name (First, Middle, La	st)		Wait	ress	3	18 Mothe	ar's Nama	(First Middle	Cate Maiden Suma	ering		
Maryland 21215-0036	uld be I Mental I Irked o	To Be	Karol Lenkowski	·							lovich		une)		
Man	2 sho and 1s ma		19a. Informant's Name/Relationship									er, City or Tow		o Code)	
	1 and Health em 27 ther t		Joan Kosta (Dau 20a. Method of Disposition	gnter)	20b. I	Place of Dispo	osition (A	lame of	1	_	enstown	, MD 2		own State	
nor	ages ant of it: If it y or o		1XDBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate	cemetery, cred Ly Rood	matory o	r other place	l l		5-2005		•	New York	
Baltimore,	permit. F Departme Importer eny injur		21. Signature of Funeral Service Lic		110.	-	2. Name Hai	and Addres	s of Facility Fun	y eral	Home,	P.A.			-
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	sed the dea	th. Do not en						polis,	rw 21	Approximate	
	Physician		tmmediate Cause (Final disease or condition	Pal	ologi	- Va	Na	1800	o A	CC	icleu	1		Interval Betwee Onset and Deal	h
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):					00				
		- G	Sequentially list conditions if any, leading to immediate	b. Due to (or	as a consec	quence of):									
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,									
oʻ	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to (or	as a consec	quence of):									
8760,	ate be hysici the bu	dicai		d											
Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outco	n 2∐Feta tattime olo	al death 3[∃Ectopic] Other (pregnancy specify)					ate of deliv	ery Day Year	
P.O.	at the	Phys	9 Unknown	9∐ Unknow											
rds,	w requires that been signed b should be det	þ	Part II. Other significant conditions	s contributing to deal	h but not res	sulting in the u	nderlying	rcause give	on in Part I.			obacco use co Yes 2 □ No	ntribute to t 3 ☐ Prol	he cause of death bably 4 Dunkr	9
9	e law re has bee ge 2 sho	Completed									24a. Was	an 24b	. Were auto	opsy findings avai	lable
= =		Con									perfo	rmed?	death?		, 0.
Vita	Physicien: Th r this certificate rat director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0150		of Death	(Check only o	one)			
o	두 두 등	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inp		28b. Time o		28c. Injury	NU NU			dence 6 0		fy)	
on	Attending or death.	atior	Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month,	Day Year)	Injury	М	Work	:? /es 2 □ l		.00. 500000	now injury cook			
Division of Vital Records,	i dia di	Certification;	3 Suicide 6 Could not determine	ad 289. Place of	Injury - At h , etc. (Speci	ome, larm, str	reet, lact	ory, office		2	281. Location (3 City or Tox	Street and Nur wn, State)	nber or Rura	al Route Number,	
	To the Hospitei within 24 hours a To the Funerel I completely filled	edical (29a. Certifier (Check only) 2 Medical Ex	Physician: To the be aminer: On the base and manner	s of examina	owledge, deat ation and/or in	h occurre vestigati	ed at the timon, in my op	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and r date and place	nanner as s , and due t	stated. o the cause(s)	
	To the within To the Comp	Me	29b. Signalare and title of certifier				2	9c. License	number			29d. Date sign	ed (Month.	Day, Year)	
			1					D	571	02	8	11.2	3-0	55	
			30. Name and address of person wh		5"	m 23a) (Type,	Print)	, tt	7-21	A==		1.2		21401	
	Sta	te.	Aditya Chopre 31. Date filed (Month, Day, Year)	32. P.	istrar's Sign	ature 81	4	UC. T.	201	MY	napo	115,1	10.2	21401	
	Registr			2005	allen a	K	San A	2 0							

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1^{Day}, **Physician** 8:30 P M 2005 Ralph K Shumaker Jr. Nov. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5804A Lantana Circle Frederick Frederick 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 65 1940 D. 217-36-9702 C. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ir then "neturel", or items 23e or 28a-f ehow tre Modical Examiner must be notified at 1 XYes 2 No MDFrederick Frederick Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5804A Lantana Circle 21703 USA Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1960 If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry county Elementary/Secondary (0-12) College (1-4or 5+) government fireman permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other It eny injury or other traumatic event, Its 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ralph K. Shumaker SR. Kathleen Rider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Boyle (Daughter) 416 Lincoln Ave., Collingswood, N.J.08108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/299005 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg, MD Smithsburg Crematory ' 4 ☐ Donation 5 ☐ Other (Specify) T. Signa ure of Funeral Fervice Licenses Bonald ddd B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, san failure. List only one cause on each line. Approximate Interval Between Onset and Death Fart1. Ente eart failure. Hopestensive Condio Vocalor Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to g as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed rattending physician and I for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by to Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1XYes 2□No 3□Probably 4□Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes No 1 Tes certificate Attending Physician: After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A death. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier an 11/28/05 722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registre's Signature 31. Date filed (Month, Day, Year) NOV. 3 0 State 2005 Registrar

			_ For	State of Maryland	d / Departme	nt of Health and M	-	•	L0261
			= State Registra AMEND#7perdaug 1. Decedent's Name (First, Middle, Las		1606 Certifica	ite of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physici /Medic		FLORENCE:	ANNE /	920	A	Mohity a	23 200	05 2:444
	Examin	er	4a. Facility Name (If not institution, give	KOAD	4b. C)	OTOMAC	/	10NT	COMERY
To the same	Funeral Director		10 00 1616		Month	der 1 Year II Under 24 Hrs. s Days Hours Min.	8. Date of Birth Month Day	933 E	inthplace (State or Fordign Country)
	land		Usual Residence of Decedent 10a. State 10b. County	10c. 9 /fy	Town or Location				10d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	ector	MD MONTG	OMERY to	TOMAC	7	140	0:::	1 KYes 2 No
	23a or 2	Funeral Director	10e. Street and Number TALLS	ROAD	107.	20854	109.	Citizen of What C	Sountry?
9	e E E		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No	If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 2- No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Arr Black, Wh	
5-0036	72 hours after naturel', or Ita	ed by	3 ☐ Widowed 4 ⚠ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates:	16a. Decedent's U	sual Occupation	16b	Specify:	// / / C
21215	d within 72 giene. r then "na	Completed	(Specify only highest gra	College (1-4or 5+)	(Give kind of life, DO NOT	work done during most of work use retired) ELED N.C.	RSF (ARE	GIVER
	othe	Be Co	17. Father's Name (First, Middle, Last)	γ_{\perp}	// - / - /	18. Mother's Nam	ne (First, Middle Maid		1
Maryland		ToE	Informant's Name/Relationship (>ALUTE	19. Mailing Addre	ess (Street a.) Number or Ru		ARC H	NOEZO
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic	4	BRUCE TODA	SON	47695.	E. HICHOR	AGE De.	STUAK	V, FI 34997
Baltimore,	8 2 = 5+V		20a. Method of Disposition 1 B Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ace of Disposition (A metery, crematory of	lame of r other place)	Date 25-05	Location - City of	or Town, State
Baltii	permit. Pa Departmer Important eny injury	ı	21. Signature Pureral Service Licen		d/ 22. Name 509	and Address of Facility Po		evg. A	33779
		2 14	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death	. Do not enter the m		or respiratory arrest,	y Harbor	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. A my o lo	phic 1	ateral a	sclenos	315	Onset and Death
	/Medical Examiner		resulting in death)	Due to (oras a conseque	ence of):				
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,	le be executed ysicien and e burial-transit		that init/ated events resulting in death) Last	c. Due to for as a consequ	1 2	oremay) (
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Box (eath certificate be e. attending physicien for use as the buria	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3 □Ectopic			23d. Date of d	elivery Day Year
P.O. F	that the dea ed by the a detached fo	hysic	1 ☐ Yes 2 KNo 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5 Other	(specify)			July 154
rds, F	Se De es	Completed by Physician/Med	Part II. Other significant conditions of Respiratory	Λ 4	alting in the underlying	,	23e. Did tobacc	_	to the cause of death? Probably 4 □Unknown
Seco.	e law requir has been s ge 2 should	nplet	amyo Irophic	lateral sc	120012		24a. Was an autopsy performed	24b. Were a prior to death?	autopsy findings available completion of cause of
tal	sician: The k certificate ha irector, page	e Co	25. Was case referred to medical			26 Place of Dog	1 ☐ Yes 2 🛣		s 2□ No
f Vii	Physician: this certific al director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3	Other	ome 5 Residence	6 ☐ Other (Sp	pecify)
o uo	ttending Ph death. :tor: After th : the funeral	tion:	27. Manner of Death 1. ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	nury occurred	
Division of Vital Records,	or Attendi fter death. Virector: A n by the fu	Certification:	3 Suicide 6 Could not be determined	1	me, farm, street, fact		28f. Location (Street City or Town, St		Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: Completely filled in by the	cai Ce	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinati	vledge, death occurr	ed at the time, date and place	, and due to the cause	(s) and manner and place and place	as stated.
	thin 24 thin 24 orthe F	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		Date signed (Mor	
	S Con Twith		KNONI	0.1		D23091			_23_2005
	10		30. Name and address of person who		23a) (Type, Print)	- 30 (1			
7	2 3 0	to	A. Kaldun N 31. Date filed (Month, Day, Year)	32. Registrar's Signat	115 Aubru	EN AVE; Beth	isha, MD	20814	
	Sta Regist		NOV 29	32. Registrar's Signate	y Apparl				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item: 5 per F. H. C-851 1/27/06 reb

State of Maryland 7 benaring the part of Health and Mental Hygiene 15 Registrar

Registrar Registrar For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 3:30AM Μ. 5,2005 Doris Taylor December /Medical 4c. County of Death
Prince Georges 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Accokeek der 1 Year | If Under 24 Hrs. | 15607 Henrietta Drive 5. Social Security Number 217-44-6339 If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F Yrs. 61 Director April 9,1944 Md Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Prince Georges 1 X Yes 2 □ No Director Md. Charles Accokeek 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15607 Henrietta Drive 20607 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. ģ 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) e filed within 72 h al Hygiene. I other then "natu 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 Gover nment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9DGs. Be William . Barber Chase Cora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r 15607 Henrietta Drive R Accheek, Md 20607 Patricia Taylor/daughter 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Cem. 12/12/05 Mechanicsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -unition /Medical Due to (or as a consequence of): Examiner 4 mos etrone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physicien for use as the buria To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) <u>о</u>. the detached 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2X No 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this s after death.
I Director: After this id in by the funerel d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 (Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C pelli 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai completely To the 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 8 12/07/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 ANGREN: 215 13 20052. Regultrar's Signature Pennsylvania Ave NW Washington, Dc James State Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Eileen Angela Anderson Thompson November 28, 2005 5:00 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 582 Wilson Bridge Drive # B-1 Oxon Hill If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 39 1 M 20 F 224-31-3837 Director 8/18/66 <u>Bakersfield,Cali</u> Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or items 23a or 28a-1 ehow The Medical Evantinar must be notified at P.G. Md. Oxon Hill YOYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 582 Wilson Bridge Drive # B-1 20745 U.S.A. 14. Race - American Indian, Black, White, etc. American 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: ģ 3 Widowed 4 Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) 11th College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed v iment of Health and Mental Hygie 1ant: if Item 27 ie marked other t jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmund R. Anderson Patricia L. Keontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Tyrone Thompson/Husband 582 Wilson Bridge Dr. #B-1, Oxon Hill, Md. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: if any injury or once. Chesapeake Crematory, Inc. 11/30/05eltsville, Md. 21. Signature of Funeral Service Licensee H.S. Washington & Sons Co., Inc. Mit Guu 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Symptomatic HIV infection **Physician** 1993 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed inding physicien end use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the atter in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 99 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by sigr 1 be 1 Yes 2 No 3 Probably 4 Unknown beer si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate hes autopsy performed certificate 2 □ No 1 Yes 2 **2** No 1 Yes Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М death investigation 2 Accident in by the ector: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital o within 24 hours aff To the Funeral DI completely filled in 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0024064 November 29,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shantha K. Murthy, M.D. 6196 Oxon Hill Road # 520, Oxon Hill, Md. 20745 31. Date filed (Month, Day, Year) NOV 2 9 2005 . Registrar's Signature-State Registrar

		1	For State Registrer	State of Maryl	and / Depa <i>Cer</i>	rtment of H	ealth and M Death	-	ene () 5 [0264
1	Physicia		Decedent's Name (First, Middle, Las ESTER	t)	WILLIAM	S. JR.		2. Date of Death NOVEMBER		3. Time of Death 9:30 P M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	7.30
	Examin	er	1914 Callaway			Temple	Hills		Prince G	eorges
	Funeral Director		5. Social Security Number 6. S		yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) March	9. Birth Cou 21, 1930	place (State or Foreign ntry) NC
	DUE ≱	-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	darylis f sho	ō	MD PG		•	le Hills	3			1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number		1011112	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	23e o	a D	1914 Callaway	Street		20748		1	United St	ates
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White	
20	be filed within 72 hours after death with the Maryland ital Hygiene. Add other then "natural", or items 23e or 28e-1 show event. The Modical Evaminating the rediffical at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYPes 2 □ No If Yes, Give KO Year or Dates:	REAN	1 ☐ Yes 2 ☐ X No	Specify:		Specify: Bla	ale
215-0036	stural stural		15. Decedent's Ed	Jucation	16a. Dece	dent's Usual Occupa			6b. Kind of Business/Ir	
دا 2	- 40	plet	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor.)	king		
	filed wit Hygiene other the	Completed	12		Spec	ial Pol		(P) A A C 4 H B A	DC Gove	rnment
⊆	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event. Its Ms	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M.	aiden Sumame)	
<u> </u>	is 1 and 2 should of Health and Men item 27 Is marke othar traumatic	ဥ	Ester Williams 19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a	Albert		City or Town, State, Zi	o Code)
Z Z	and 2 sealth an n 27 is i		Lucille Willia		1914	Callawa 10 Hills	ay Stre			
	s 1 and 2 if Health item 27 l		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of natory or other place			0c. Location - City or T	own, State
Ë	0 0		1 ☑Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State		erans Ce		15/05	Che1tenh	am, Md.
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Euneral Service Licer	1500				_	Edwards	
	202 20		Lerry	popular					Suitland,	
			23a. Part1. Enter the disease of comshock, or heart failure. Vist only			er the mode of dying	g, such as cardiad	or respiratory arres	St,	Approximate Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	LUNG CAN						
	Examiner			Due to (or as a co	nsequence or):					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):				K	
	nd nd transit	Examlner	Cause (Disease or injury that initiated events	c						
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence ot):					
8760	physicate t	dlcal	•	d						
Box 6	leath certific attending pl	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Der			23d. Date of deliv	rery
ă.	that the death cer ed by the attendin detached for use	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 □ 4 □ Pregnant at time		Ectopic pregnancy Other (specify)			Month	Day Year
P. 0.	at the d by the stached	hys	9 🗆 Unknown	9□ Unknown				an Busi		
ŝ	es be		Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to s 2□No 3□Pro	•
Record	w requir been si should	Completed						24a. Was an	24b Ware out	opsy findings available
Rec	has l	ldm						autopsy perform	nrior to co	ompletion of cause of
Vital		0	25. Was case referred to medical				26. Place of Dea	1 Yes 2		2(X No
<u> </u>	Physician: The la this certificate had ral director, page 2	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Oth	or		nce 6 Other (Spec	ify)
J Of	ng Ph ter th neral		27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	f 28c. Injun Worl	y at k?	28d. Describe how	w injury occurred	
Siol	Attending r death.	catle	2 Accident investigatio	n			Yes 2□No	206 1 11 / Ch-	- A	Toute Museline
Division	i in the	Certification:	4 Homicide determined		At home, farm, st Specify)	reet, factory, office		City or Town,	eet and Number or Rui , State)	ar Houte Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1X Certifying Pl	nysicien: To the best of m	y knowledge, deat	h occurred at the tin	ne, date and place	, and due to the ca	use(s) and manner as	stated.
	e Hos 124 h e Fur letely	edical	(Check only 2 Medical Example)	miner: On the basis of exa and manner stated.	amination and/or in	vestigation, in my o	pinion, death occu	irred at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifien	10		29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
)			b Cly	1 64cm	ras	MD# 20	0459	NO	VEMBER 28,	2005
2	(12)		30. Name and address of person who							
	Sta	ate	ANTHONY ARCENAS, M 31. Date filed (Month, Day, Year)	a. Registrar's	Signature-		NW, WASH	LNGTON, DC	20422/688	
	Regist		NOV 2 9 200	5 leen	It April	AL.				

State of Maryland / Department of Health and Mental Hygiege Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7:06P M MAURICE EDWARD WOMBLE NOVEMBER 2005 18, /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** XXM 2□F 13, WASHINGTON, DC Director 578 68 4023 1954 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at XXYes 2 No Directo DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1050 44TH STREET, NORTHEAST 20019 UNITED STATES Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after at Hygiene. I other than "natural", or itel XIX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🔀 No If Yes, Give Year or Dates: Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH MAINTENANCE ENGINEER GOVERNMENT permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked othe any injury or other traumatic svent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ JOSEPH BOONE ALFREDA WOMBLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOREATHA WOMBLE / SISTER 216 36TH ST. NE WASHINGTON, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) HARMONY MEMORIAL PARK 29 NOV 2005 LANDOVER, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. Taks 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part I enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 225 ardio **Physician** telmonor /Medical resulting in death) Due to (or as a consequence of) **Examiner** 1092 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached to ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4XXUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed 1 Yes XXNo To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No ို 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BG0163080 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN GREENE, M.D. SOUTHERN MARYLAND HOSPITAL CENTER CLINTON, MD 20735

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 8 2005

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 12, 2005 6:40 AM M Otis Wingo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1**⊠** M 2□ F 226-30-4374 80 18, 1924 Arkansas Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Health and Mental Hygiene.
ant: if item 27 ie marked other than "natural", or Items 23a or 28a-f ahow ury or other traumatic event, the Medical Examinar must be collidat at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No **Funeral Director** Washington, DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20011 USA 839 Kennedy St. NW 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) **4yrs** Flementary/Secondary (0-12) Pilot. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Watson Robert E. Wingo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 839 Kennedy St. NW Washington, DC 20011 Stacey Ann Lucien/Great-niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Quantico Nat. Ceme. Nov. 28, 2005 Triangle, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Johnson and Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy Street NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Munknown DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PERIPHERAL VASCULAR DISEASE 24a. Was an certificate has autopsy 2 **X** No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA TIS. After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending death. 1 Tes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Mn D32332 November 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NOV 2 8 2005

31. Date filed (Month, Day, Year)



	1	1 - State Registrar			Cer	tificate of	Death		Reg	. No.		los U
		1. Decedent's Name (First, Middi	e, Last)					2. Date of		Day \	rear	3. Time of Death
Physicia /Medic		Olive Aurora	Wheeler							24, 20		10:37 A ^M
Examin		4a. Facility Name (If not institution	n, give street and number,)		4b. City, Town, o	r Location o	of Death		4c. County of		
		WASHINGTON ADV	ENTIST HOSPI	TAL		TAKOMA				MONTGO		
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birt		If Under 1 Year Months Days	If Under 2	Min. (Monti	of Birth h, Day, Y	ear)	9. Birthpl	ace (State or Foreign try)
Director		577-64-3701	I I W ZLA	75	Yrs.			Apri	L 14	, 1930	Tri	nidad
and *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					10	Od. Inside City Limits
sho	5		_			ille						1 √ Yes 2 No
the A	ect	MD Princ 10e, Street and Number	e George's	пуац	LSV	10f. Zip Code			100	. Citizen of Wh	at Count	trv?
72 hours after death with the Maryland natural, or Items 23a or 28a-f show areal Executes must be notified at	Funeral Director	6605 23rd Ave.				2078	32			Trinida		
eath	era	11. Marital Status	12, Was Decedent	Ever in U.S.	13. V	as Decedent of H	lispanic Orio	gin? (Specify Yes		14. Race		an Indian,
iter d	Fun	1 XNever Married 2 ☐ Mar	Armed Forces	?	If	Yes, specify Cubi	an, Mexican	, Puerto Rican, etc	:.)		White, e	
urs a	þ	3 Widowed 4 Divorced	If Yes, Give		1	☐ Yes 2. 4No	Specify:			Specify:	B1ac	k
2 ho	Completed	15. Deceder	it's Education	16a.	Deced	ent's Usual Occup	ation	t of working	16	b. Kind of Busi	iness/Ind	lustry
thin 7	ple	Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	life. D	O NOT use retire	d)	or working				
d wil	Son		5	Gui	idar	ce Couns				Private		
al Hy al Hy toth	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (First, M	iddle, Ma	iden Sumame))	
should be filed within nd Mental Hygiene. i marked other than umatic event, Ite Mar	2	Charles Whee	ler				Lu	ıcy Cordn	er	_ = =		
2 sho and Is my		19a. Informant's Name/Relations						r or Rural Route N			tate, Zip	Code)
es 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. If item 27 is marked other than "netur		Merle Wheeler/S	ister					tsville,	-			
of H.		20a. Method of Disposition 1 XBurial 2 Cremation	3 ☐Removal from State	20b. Place of cemeter	Dispos y, crem	sition (Name of natory or other pla	ce)	Date	20	c. Location - C	ity or To	wn, State
permit. Pages Department of Important: If it any injury or o		4 □Donation 5 □ Other (I .	Pu	blic Cem	e. De	ec.5,2005	To	co, Tr	inid	ad
permit. Departitimporta		21. Signature of Funeral Service	Licensee	J 1								neral Home
1 205 2		Della	Higher	~				NW Wash			2001	
		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications hat cause tooly one wase on each	d the death. Do r	not ente	r the mode of dyir	ng, such as	cardiac or respirat	ory arrest			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	RC	-9 PIR	149	でんり	F	MLUR	E			Onset and Death
/Medical		resulting in death)	Due to for a	s a consequence	of):	2RU	0	1BO L1				D 4-40
Examiner		Sequentially list conditions	0			717	0 10	10021			2	Months
₽ #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):	Can	(C.SZY)	COF	CO	100	1	Manlo
acute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c. DIGI	173 /71		VAI	7007				12	ronorg
e execution a		resulting in death/ cast	Due to (or as	s a consequence	or):							
sate b	dica		d									
ne death certificate be executed the attending physician and hed for use as the burial-transit	Medical	IF FEMALE:	00-14									
uires that the death cer signed by the attendin d be detached for use	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnanc	у			23d. Date Monti		ry Day Year
the a	Physician	1 ☐ Yes 2 Wo 9 ☐ Unknown	4⊟Pregnant a 9☐ Unknown	at time of death	5 🗆	Other (specify) _						
hat the deby		Part II. Other significant conditi	ions contributing to death	but not resulting in	the un	iderlying cause on	en in Part I.	23e.	Did tobac	cco use contrib	oute to th	e cause of death?
signe signe	i by					,g g			1 🗆 Yes	5.0	Proba	
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a law has t	npl	<u> </u>							Was an autopsy performe	pri	ere autop or to con ath?	psy findings available npletion of cause of
ysician: The lav	S							10)	es 20	No 1E	Yes	2□ No
ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			0#		of Death (Check of				
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ling F	lon	1 Natural 5 Pend		ay Year)	njury	28c. Inju	ryat rk?]Yes 2.⊟1		HOW HOW	пригу оссите	u	
tend death tor:	icat	2/□ Accident invest 3 □ Suicide 6 □ Could	not be	sium. At homo fo	em ete		105 2 1		ion (Stree	et and Number	or Rura	l Route Number,
or All	Certification:	4 - Homicide determ	building, e	njury - At home, fa atc. <i>(Specify)</i>	iiii, stre	set, ractory, office			r Town, S		01710701	riode ridinosi,
To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attence completely filled in by the funeral director, page 2 should be detached for us		29a. Certifier 1 Certify	ng Physician: To the bes	t of my knowledge	death	occurred at the ti	me date an	d place, and due to	the caus	so(s) and man	ner as st	ated
Hos 24 hc Fun stely	edical		Examiner: On the basis and manners	of examination an								
o the ithin i	Me	20h Signaturk and title of contifu	as Re			29c. Licens	se number		29d	. Date signed ((Month, L	Day, Year)
F 3 F 8		tod	How and,	4 RD-		100	281	45	1	1-75	-1	05
(()		20 Name and address of news	who completed sauce of	death (Item 22c)	(Type !	Print)					e a s	TOTAL STATE
2 (10)		30. Name and address of person	GUORAY, M	0, 145	0	MERCH	DUT (LE LN.	LA	R60,	MO	2.20774
Sta	ite	31. Date filed (Month, Day, Year	r) Regis	trar's Signature								
Registi		NOV 2 8	2005 Medica	trar's Signature	Ser.							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene Reg. No.)5	40268
	Dhysisi	200	1. Decedent's Name (First, Middle, L	ast)				2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Margaret	Helen	Wh	itlev		NOVEMBI		2005	10:49am M
	Examin	er	4a. Facility Name (If not institution, ga				, or Location of Dea	ith	4c. Cou	unty of Death	n
			CIVISTA MEDICAL			LA P			CHAR		
	Funeral Director		5. Social Security Number 6. 578-34-5685 Usual Residence of Decedent	Sex 7. Age (In yrs 1 ☐ M 2X F 76	S. last birthday) Yrs.	If Under 1 Year Months Day			th ay, Year) • 1929	9. Birth Col Wash	nplace (State or Foreign untry) nington D.C.
	show		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Man	ţŏ	Maryland Cha	rles	1	aPlata				Į.	1 ☐ Yes 2 No
	ith the Mi or 28a-f	Director	10e. Street and Number	11 103		10f. Zip Code)		10g. Citizen	of What Co	untry?
	after death with the Maryland or Itams 23a or 28a-f show culter court be rediffed at		9255 Sadie Lane			2	20646		U.S	Δ	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		f Hispanic Origin? (Jban, Mexican, Pue	Specify Yes or No		Race - Amei	
9	or Ita		1 Never Married 2 Married	1 Yes 2XXNo		1 □ Yes XXXN		no nican, etc.)		Black, White	e, etc.
21215-0036	hours after ural', or ita	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:		1 163 MAIN	о зресну.		Spe	ecify: Wh	nite
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12		mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti	red)			0	
	ba filed withir tal Hygiene. d other than		12 17. Father's Name (First, Middle, Las		sec	retary	10. Mathada Ni	(Fire Middle	U.S.		ment
and	Q 22 D	Be		51)				ame (First, Middle,	, Maiden Sun	name)	
Ž	2 should ba and Mental is marked of reumatic eve	10	Robert Tranmer	(Toron 1974)	404 14 10		Irvie				
Maryland	s 1 and 2 should f Health and Men item 27 is marka othar treumatic		19a. Informant's Name/Relationship				et and Number or F				
	is 1 and of Health item 27 othar tr		Robert E. Gibson/ 20a. Method of Disposition		Place of Disno	Sadie L	ane, LaP	lata, Mar Date			
ور	0 0		1 X Burial 2 ☐ Cremation 3	Removal from State	cemetery, crei	natory or other p	· 1		20c. Location		
Baltimore,	rimer rient		'4 □Donation 5 □Other (Spec					-30-2005	Chel-	tenham	n, Maryland
Ba	permit Pag Deparment Importent: if any in ury o		21. Signature of Funeral Service Lice	ham Moods	H		eral Home	e Waldo			d 20604
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the dea y one cause on each line.	ath not ent	er the mode of dy	ying, such as cardia	ac or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. ACUTY	USG	WAL 1	1 SEAT	INVE			Onserand Death
	/Medical		resulting in death)	Due to (or as a conse	-	1					0.30
9	Examiner	.	Sequentially list conditions.	6. Hupste	U-22W	M.					× Dogs
	p #	inel	Sequentially list conditions, Tarry, leading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated executions).	Due to (bras a conse	quence of):						0
	and and I-trans	Examiner	that initiated events resulting in death) Last	e ALTY	KRY	PIPE	TORUN	LATTO	Will .		× Days!
30,	be executed ician and burial-transit	Ê	rooding in obdity East	Due to (or as a conse							4
8760	ate ohys the	dicai		q = 1 2 100.	F.K. W.	1117				-	
9	eath certific attending p I for use as	Me.	IF FEMALE:	20- 1/							
Вох	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel	tal death 3	Ectopic pregnan	ісу			Date of delive	very Day Year
0	the de y the a cched f	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				MOUTH	Day real
P.	ac oc	Phy			ht to						
Records,	w requires that been signad b should be deta	۵	Part II. Other significant conditions	contributing to death but not re	suiting in the u	nderlying cause g	jiven in Part I.		obaccousec Yes 2 □ No		the cause of death? bably 4 Winknown
ecc	aw as b	Completed						24a. Was		b. Were aut	opsy findings available ompletion of cause of
E	Th ate pag	Con							rmed?	death?	2□ No
Vital		Be (25. Was case referred to medical examiner?				26. Place of De	ath Check onl o			
of V	Physicien: this certific al director,	10	1 ☐ Yes 2 No	Hospital: 1 Hopatient 2	☐ ER/Outpatier	t 3□ DOA O	ther: 4 \(\text{Nursing}	Home 5 Resid	dence 6 🗆	Other (Speci	ify)
o u			27. Manner of Death 1 Aatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	ury at ork?	28d. Describe h	now injury occ	curred	
0	Attending r death. sctor: After by the fune	ati	2 Accident investigation				☐ Yes 2 ☐ No				
Division	or Att	Certification:	3 Suicide 6 Could not determine		home, farm, str	eet, factory, office	Ð	28f. Location (S City or Tox	Street and Nu vn. State)	mber or Rur	al Route Number,
Q	ital c rs af rei D led ir	Cei		4				1			
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier Check only one) Certifying P	Physicien: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, death ation and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the ourred at the time,	cause(s) and date and plac	manner as see, and due t	stated. to the cause(s)
	Withir To the Comp	M	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date sig	ned (Month,	Day, Year)
			1/ Jun 1/	Moh	_		206	29	111	25	15
0			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)					2
	BID		CTIESTICY	White Is	736	> MY	MB	LDVR	FN	Ul 2	0003
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9	2005 32. Redistrar's Sign		bode	-				

	For State Registrar	State of Marylan	d / Department of Health and Certificate of Death	d Mental Hygièi Reg.	.000 10205
Physician /Medical	Decedent's Name (First, Middle, L ANNA RIT.	A WALL	4b. City, Town, or Location of Di	NOV.	Day Year 3. Time of Death 7:30 P 4c. County of Death
Examiner Funeral Director	4a. Facility Name (If not institution, g. SALISBURY REHAB 5. Social Security Number 6.		R SALISBURY, MD. ast birthday) If Under 1 Year If Under 24 H	21804	WICOMICO
	Usual Residence of Decedant 10a. State 10b. County MD WICO		, Town or Location ALISBURY		10d. Inside City Lim 1 ⊈ Yes 2 ☐ t
1215-0036 within 72 hours after death with the Maryland ane. then "neture!', or items 23a or 28a-f ehow he Madical Execultational be notified at ampleted by Funeral Director	10e. Street and Number 200 CIVIC AV 11. Marital Status	12. Was Decedent Ever in U. Amed Forces?	S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		Citizen of What Country? 14. Race - American Indian, Black, White, etc.
15-0036 72 hours after de "neturel", or item idical Executient	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 Tes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b	Specify: WHITE . Kind of Business/Industry
nd 2 be filed tal Hygi d other event, 1	17. Father's Name (First, Middle, Las	College (1-4or 5+)	NURSE LPN 18. Mother's	Name (First, Middle, Maid	,
WAALL Ore, Maryla 88 1 and 2 should 1 10 thealth and Men if item 27 is marke, ir other traumatic.	SOHN GAY 19a. Informant's Name/Relationship LAURA BRUSH	DAUGHTER	19b. Mailing Address (Street and Number of	E, MD 218	ry or Town, State, Zip Code)
R. Millimo	20a. Method of Disposition 1	□Removal from State SA	lace of Disposition (Name of emetery, crematory or other place) SBURY CROMM TCRU Name and Address of Michigan	23-2005 54	Location - City or Town, State AUSBURY, MD PO BOX 61
AN	Immediate Cause (Final	mplications that caused the death to one cause on each line.	n. Do not enter the mode of dying, such as car	51 31 KIA	Approximate Interval Between Onset and Death
Physician /Medical Examiner	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to for as a consequence of the Due to for as a consequence of the Due to for a consequence	· Sur Loor	la lor	year.
68760, froate be executed physician and is the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):		
IS, P.O. Box 6 res that the death certific ligned by the attending to be detached for use as by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
cords, P. wrequires that been signed be determined by the property of the prop		contributing to death but not res	ulting in the underlying cause given in Part I.	1 🗆 Yes	co use contribute to the cause of death? 2
on of Vital Record ding Physicien: The law requir h. After this certificate has been s funeral director, page 2 should			26. Place of	24a. Was an autopsy performed 1 ☐ Yes 2 ☑ 26ath (Check only one)	
Division of Vital Records, P.O. Box (tal or Attending Physician: The law requires that the death certifus after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use a property of the funeral director.	1 ☐ Yes 2 ☐ M6	ha -	28b. Time of Injury Mork? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how i	
Div rs afte ra Dire		building, etc. (Specification) Physician: To the best of my knoeminer: On the basis of examina	ome, farm, street, factory, office wledge, death occurred at the time, date and p tition and/or investigation, in my opinion, death of	City or Town, S	fate) e(s) and manner as stated.
To the Hospi within 24 hou To the Funer Completely fil	one) 29b. Signature and title of centifier	and manner stated.	29c. License number DZ 934	29d.	Date signed (Month, Day, Year)
Pa	CA Data Mad (Made) Dev Made)	M.D. 200 CIVIC	AVE., SALISBURY, MD.	21804	
State Registra	MOVO	9 2005 32. Redistrar's Signa	B. Sparte		

Thomas L. Young 05 - 7752AG

the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital or Attending Physicien: Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiện () 1- State Registrar Amend# 16a.Per FH PCC 11-28-05 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7, 2005 **Physician** Thomas Leroy Young November 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cheverly

If Under 1 Year II Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 05/22/1973 Prince George's Prince George's Hospital Center 7. Age (In yrs. last birthday) e (State or Foreign **Funeral** 1**X** M 2□ F 217-90-3914 32 Yrs. Washington, C Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or then "natural", or items 23s or 28s-f ehow the Medical Exercines coust be notified at D.C. Washington Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1132 16th Street, N.E. #2 20002 USA permit. Pages 1 and 2 should be filed within 72 hours after death \\
Department of Health and Mental Hygiene. \\
Important: if item 27 is marked other then "natural", or items 23\\
eny injury or other traumatic event, the Wedical Examiner must
eny injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes XX No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working CDL Truck Elementary/Secondary (0-12) College (1-4or 5+) Driver 10ch Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas L. Young, Sr. Llewellyn Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Llewellyn Hall - Mother 2696 Kirk Drive; Waldorf, Maryland 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cometery, crematory or other place)
Mount Olivet Cemetery 11/22/05 Washington, D.C. 22. Name and Address of Facility Freeman Funeral Services Funeral Service Licenses P.O.Box 416; Suitland 20752 Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one backs on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nushel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, ii arry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy performed? 1 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ XXYes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 26:04 1 ☐ Yes 2 No 11/16/05 2 Accident filled in by the 28f. Location (Street and Number of Rural Route Number City or Town, State) 5319 East (april 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Store Striet 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 17, 2005 cause of death (Item 23a) (Type, Print) MILLERA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 2 8 2005 Registrar

DHMH 17 Rev 1/2001

this

After

Director:

death.

		•	For State Registrar	State of Ma		artment of H		Mental Hygie	ene .M.AAS	10071
	44	2	Decedent's Name (First, Middle, Last	it)		tinoate or t		2. Date of Death	NO.	3. Time of Death
М	Physici	_	Ethel Elise Ar	miger				Month December	9, 2005	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	1	4c. County of D	
			Frederick Villa			Catons	ville		Balt:	imore
	Funeral		Social Security Number 6. S		(in yrs. last birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of Birth		Birthplace (State or Foreign
ů.	Director		219–28–7478	□M 2 ⊠ F	95 Yrs.	Months Days	Hours Mir	s. 8. Date of Birth (Month, Day,) Feb 28,	1910 M	aryland
	D >		Usual Residence of Decedent 10a, Stale 10b, County		10c. City, Town or Lo					Trail and the second
	ehor	5			-	altimore				10d. Inside City Limits 112 Yes 2 ☐ No
	28e-f	Director	Maryland n/a 10e. Street and Number					1.40	000	
	be filed within 72 hours atter death with the Maryland hat Hygiene. Id other then "natural", or Itame 23e or 28e-f ehow other then "natural", or Itame 25e or 28e-f ehow event, I'm Medical Exerting transities incitified at		3838 Roland Avenu	e #1303		10f. Zip Code 2121	1	100	g. Citizen of What United	
	leath ne 23	Funerai	11. Marital Status	12. Was Decedent B	ver in U.S. 13.			Specify Yes or No-		merican Indian,
(0	riter	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖸 N	0	If Yes, specify Cuba	n, Mexican, Pue	erto Rican, etc.)	Black, W	hite, etc.
Ö	ral', o	۾	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2½ ∏ No	Specify:		Specify:	White
21215-0036	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occupa	ation furing most of w	orkina 16	b. Kind of Busine	ss/Industry
7	n dithin	ig I	Elementary/Secondary (0-12)	College (1-4or 5-	+)	kind of work done of DO NOT use retired)		D1 1	
2	iled v Hygie her t	ပိ	12 17. Father's Name (First, Middle, Last)	2	Bai	nk Teller	10. Motherie Ni	ame (First, Middle, Ma	Bankir	ng
Maryland	of of	Be						ame (First, Middle, Ma a Mills	uden Sumame)	
Z	hould Me Ind Me	ဥ	Francis McGreevy 19a. Informant's Name/Relationship (1)		19h Maili	na Address (Street a		Rural Route Number, (Tity or Tourn State	o Zin Codol
<u>8</u>	id 2 s ith an 27 ts treu		Edna Shearer / Da					Baltimore		· ·
ō,	Hee Hee tem		20a. Method of Disposition	lugiteer	20b. Place of Dispo	sition (Name of			c. Location - City	
DE.	Pages nent of I ant: If Its ary or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			natory or other place	1 1	/12/05 D	1+imomo	Marriand
Baltimore,	그 된 원 중 .		21. Signature/of Funeral Service Licen			Mem. Par 2. Name and Addres		/13/05 Ba Hubbard Fui		, Maryland
ä	Depa Impo eny ir		Ilnn Kon	NC)						yland 21229
	X		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	the death. Do not enl					Approximate
	Physician :		Immediate Cause (Final disease or condition	(HD and		TT) 110 (TT-	V15 /	ULMONA	201 Di	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	JACO 1	· C		! - 1 1 1 1	161156
ζ	Examiner		Sequentially list conditions,	b						
Ш	D ≅	ner	if any, leading to infinediate cause. Enter Underlying		t consequence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	icate be executed physicien and the burial-transit	Ē		Due to (or as a	consequence of):					
87		dicai		. d						
×	that the death certified by the attending properties as		IF FEMALE:	23c. If yes, outcome of	of pregnancy					
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 pronths?	1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
o	the d y the ched	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	ano or death 30					
<u>α</u>	The law requires that the death certifi vie hes been signed by the attending cage 2 should be detached for use as	y P	Part il. Other significant conditions c	ontributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute	s to the cause of death?
rds	quires n sign	d by						1 ☐ Yes	2 □ No 3 □	Probably 4 Donknown
00	w require s been si should t	jete						24a. Was an	24b. Were	autopsy findings available
Vital Records,	The tay te hes age 2	Completed						autopsy performe	prior death	to completion of cause of
ta	iclan: Th certificete rector, pag	0	25. Was case referred to medical				26 Place of D	1 ☐ Yes 24 eath (Check only one)	10 10Y	′es 2.27No
\geq	Physiclan: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital:	nt 2 ☐ ER/Oulpatier	nt 3 DOA Othe	· ·	Home 5 ☐ Residen	ce 6 ∏Other /S	Specify)
0	ding Ph h. After thi funeral		27. Manper of Death 1 □ Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injury Work		28d. Describe how		
<u>\o</u>		atic	2 ☐ Accident investigation	1			Yes 2 □ No			
Division of	l or Attendation of the Control of t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	urs a pref D									
	To the Hoepital or At within 24 hours after or To the Funeref Direct completely filled in by	Medicai	29a. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner e and place, and o	as stated. due to the cause(s)
	ithin ithin ithe	Me	29b. Signature and little of certifier	and manner sta	180.	29c. License	number	290	1. Date signed (Mo	onth Day Year)
1	F 3 F 8		Jasingen 1	Lallin	11.	1	28195		12/14/2	
1			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print) A	1		-11/10	7
(0' /		TASNEEM (AKHA	V1, 72	20 PAR	k H.	ELCOHO	AVE	BAEDMI)
	Sta	ite	31. Date filed (Month, Day, Year)	32. Anglistra	r's Signature			- , , , -		21208
*	Registi	ar	DEC 1 4 2	1005	K A	2246)				

J _ J			For State Registrar	State of Maryland /	Department of Certificate of		ntal Hygien	000	+0272
			Decedent's Name (First, Middle, Las.)				. Date of Death		3. Time of Death
	Physici: /Medic	al	Phyll		rderson	D:	ECEMBER	8, 2005	1042 A ^M
	Examin	er	4a. Facility Name (If not institution, give 1600 WAVERLY WAY	street and number)	4b. City, Town, BALTIMO	or Location of Death	40	County of Death	
	Funeral		5. Social Security Number 6. Se		birthday) If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	9. Birthp	lace (State or Foreign try)
	Director	4	119-26-40-1	□M 2D(F 6 7	Yrs. Months Days	Hours Min.	Month, Day, Year	938 ma	syland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
	•-f •h	ctor	md. N	A	Baltin	nore			1 Yes 2 □ No
	or 28	Dire	10e. Street and Number	ndu Way	10f. Zip Code	1239	10g. C	itizen of What Cour	try?
	ne 23e	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.		Hispanic Origin? (Specif	v Yes or No-	14. Race - Americ	an Indian.
21215-0036	i within 72 hours after deeth with the Maryland liene. I then "natural", or iteme 23a or 28e-f ehow The Medical Examination multiper multified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cul	oan, Mexican, Puerto Ric	can, etc.)	Black, White, Specify:	acic
15-0	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation 10 de completed)	 Decedent's Usual Occu (Give kind of work done life. DO NOT use retire 	during most of working	16b. 1	Kind of Business/Inc	dustry City
212	d within liene. r then "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	,	d ministra	ton P	ublic Si	hools
	be filed ital Hygid of other event, I	BeC	17. Father's Name (First, Middle, Last)	.3	0	18. Mother's Name (F	1 .		_/
Maryland		P	Joseph	Brown St		Juan		Me Ca	
Mai	s 1 and 2 should Health and Meritem 27 ie marke other treumatic		19a. Informant's Name/Relationship (7	w - Daughter	19b. Mailing Address (Stree	(Kirk Rd))	or rown, state, zip	i 239
ore,	of Head of Head		20a. Method of Disposition	come	of Disposition (Name of stery, crematory or other plants	Date	-	ocation - City or To	wn, State
Baltimore			1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		lar till	Cem 12/13/	2005 (He	n Buen	è, md.
Balt	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service Licens	hard	Cary P. m	10 FridHILT	ion Pass	Balto.	md, 21229
ı			23a. Party. Enter the disease, or composition of heart failure. List only of	lications that caused the death. Done cause on each line.					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensiv		clevotec (avdiovas	saelar	
	Examiner			b.	ce of): DISE	ase			
	po iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):				
٧	and and III-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ce of):				
68760	icate be executed physicien and s the burial-transit	dicai		d					305
_		1 40 1	IF FEMALE:						
Box	Physician: The law requires that the death certif this certificete hes been signed by the attending rai director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnan	су		23d. Date of delive Month	ry Day Year
P.O.	by the detached	hysic	1 Yes 2 No 9 X Unknown	9 Unknown	Signature (specify)				
	es that igned t be deta	by P	Part II. Other significant conditions co	ontributing to death but not resulting	g in the underlying cause g	iven in Part I.		use contribute to th	1.
ord	v requir been si should						1 ☐ Yes 2		. 71
Records,	nelaw hesb ge 2 si	Completed					24a. Was an autopsy performed?	death?	psy findings available inpletion of cause of
Vital	iiclan: The l certificete he rector, page	0	25. Was case referred to medical	**		26. Place of Death (6	1□ Yes 2Ã N	o 1 ☐ Yes	2 □ No
of Vi	nysicia nis cert i direct	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	/Outpatient 3 □ DOA O	ther: 4 🗌 Nursing Home		6XOther (Specify	SCENE
		ioo!	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	b. Time of 28c. Injury W	uryat 280 ork? ∐Yes 2 ∐No	d. Describe how inju	iry occurred	
Division	for Attendi after death. Director: A I in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home			f. Location (Street a	nd Number or Rura	l Route Number,
Ö	s after si Directed in Directe	Certification;	4 Homicide determined	building, etc. (Specify)			City or Town, Stat	re)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atte completely filled in by the fune	Medical		ysician: To the best of my knowled iner: On the basis of examination and manner stated.					
	Withi To ti	Σ	29b. Signature and title of certifier	100-		nse number CME		EMBER 9,	
	1		rarae Ho	exan wa					
	2		30. Name and address of person who can also the canal address of the canal address of the c	completed cause of death (Item 23	a) (Type, Print) .11 PENN STRE	ET, BALTIMO	RE, MARYL	AND, 2120)1
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Lack D				
	, Registi	rar	DEC 1 4 200	5 Rodge St.	CHARLES .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ALSTON Day Year useph 2 12:30 PM a 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2718 E. Madison Street Baltimore NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 250-30-5447 3-8-18 S.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA 2718 E. Madison Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Josie Alston Josh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 2718 E. Madison Street, Baltimore, Md. Dora Alston 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Zion Cem. 12-17-05 Lansdowne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 16 real Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X nknown

Physician /Medical Examiner

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has

Director:

within 24 hours a To the Funerel L

To the

Box 68760 death certificate be

P.O. |

Division of Vital Records.

Physician

/Medical

Examiner

10a, State

Funeral

Director

28a-f show

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Funeral

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Completed

Be

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or other traumatic event, the Madical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE Š Completed Be Certification: 1 Natural 2 Accident

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical 1 Yes 2 0 27. Manner of D ath

1 Inpatient 28a. Date of Injury (Month, Day Year) investigation

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death Check only one Other: 4 Nursing Home 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number D0062194

29d. Date signed (Month, Dev. Year) 12/13/05

Baltimore, MD 21202

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

29a. Certifier

hintan 31. Date filed (Month, Day, Year)

DEC 1 4 2005

5 Pending



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens

		4	For State Registrar	State of Mary		artment of H		ental Hygien	71115	40274
	Physici	an	1. Decedent's Name (First, Midd	MACIE	B	EllAn		2. Date of Death	ay Year	3. Time of Death 2.00 AM
	/Media Examin	_	4a. Facility Name (If not institution	7		4b. City, Town, or	Location of Death		c. County of Deat	
	Funeral Director		5. Social Security Number 214 88 4753	6. Sex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	B. Date of Birth (Month, Day, Yea	9. Birt	nplace (State or Foreign unitry) M.D
	death with the Maryland ms 23e or 28e-f show rmust be notified at	tor	Usual Residence of Decedent 10a. State 10b. County A	J	City, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No
	with the	i Director	10e. Street and Number	ourst 5	+	10f. Zip Code 2/2/2	9-1950	10g. C	Citizen of What Co	untry?
	b ₽ 🖺	by Funerai	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☑ Divorce	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No 1 Yes. Give		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: B	e, etc.
	Maryland 21215-0036 d 2 should be filed within 72 hours after the and Mental Hygiene. 27 Is marked other than "natural", or the traumatic event, the Marical Examina	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed) Coltege (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working d)	16b.	Kind of Business	industry
	Maryland 2121. 12 should be filed within hand Menial Hygiene. 7 is marked other then traumatic event, the Menial Hygiene.	To Be Co	17. Father's Name (First, Middle JOE ANTY	, Last)			18. Mother's Name (First, Middle, Maide	A	Amy
	and 2 sho salth and n 27 is my		19a. Informant's Name/Relation TOE CANTY	ship (Type, Print) (FATHER)	19b. Mailin	ng Address (Street	and Number or Rural.	1	or Town, State, 2	2 15
	Baltimore, permit. Pages 1 as Department of Hea mportant: If them any injury or othermore.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 □Removal from State Specify)	A		Da (8)	10 20c.	Location - City or	Town, State
+3	Balti permit. Departr importe any inju		21. Signature of Funeral Service	ealhetree	2	431 E. OL	in ST.	BALTO, M.	of JIZ	
ő	Physician		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition	or complications that caused the st only one cause on each line	death. Do not ent))	er the mode of dyir	ig, such as cardiac or			Approximate Interval Between Onset and Death
2:0	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):		0.0(0.0)			8
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13 10	8760, sate be executed bhysician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a co	nsequence of):			_		
12	OX 6	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal déath 3	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	ivery Day Year
y w	ords, P.O requires that the seen signed by the hould be detached.	þ		tions contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.			the cause of death?
Bellan	Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for	Completed						24a. Was an autopsy performed?	24b. Were au prior to death?	itopsy findings available completion of cause of
> 5	Vital	Be	25. Was case referred to medic examiner?	Hospital		oth	26. Place of Death			11.000
Dai	Vision of Vita Attending Physician: or death. ector: After this certification by the funeral director.	ation: To	E [] 1.00.00.11	ing 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c. Injur	4 Nutsing Hom	e 5 Residence		city) [103/01ce
	Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	28e. Place of Injury - building, etc. (S	At home, farm, st specify)	reet, factory, office	28	3f. Location (Street City or Town, Sta	and Number or Ru ite)	iral Route Number,
	Haspit 24 hours Funera etely fille	Medicai (29a. Certifier (Check only one) Certify	ing Physicien: To the best of mal Examiner: On the basis of examiner stated.	y knowledge, deat mination and/or in	h occurred at the tirvestigation, in my o	me, date and place, ar pinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
4	To the within To the compl	Me	29b. Signature and title of certif	the man lake	en un	29c. Licens			Date signed (Mont	
	10/1		30. Name and address of person	n who come eled cause of death		Print)	6 - 1 1	+ Lal	the mai	2120x
		ate	31. Date filed (Month, Day, Yea	All and a second a		1 111.0	- Courso	1. 1200	10. FUIC	120%
	Regist	rar	L D	EC 1 4 2008 F	merce . All	Wastle.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 29c,d,30 per Opting 850,012/Jaf (05dhb Reg, No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Theodore Beasley 11 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver If Under 1 Year Spring Montgomery Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 ☑ M 2 🗆 F Director 277-60-8043 58 July 29. 1947 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id other than "naturel", or fleme 23s or 28s-f show avent, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9101 2nd Avenue 20910 Funeral USA. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: black à 3 ☐ Widowed 4 反 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) painter <u>private industry</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Hayes Beasley Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Mary Beasley/mother 8417 Hamlin Street Lambar, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny injury or 4 □Donation 5 ♥Other (Specify) in state 21. Signature of Funeral Service License Ronald S. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mill Baltimore, MD 21201 23 Part1. Eyer the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary artery disease /Medical Due to (or as a consequence of): Examiner Diabetes mellitus Type II if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine End stage COPD burial-tran Due to (or as a consequence of): Box 68760 Small bowel obstruction by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No O 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records. 1 Yes 2 🗆 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s 1 ☐ Yes 1 Yes 2 No 2 X No. To the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident ector: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours efter To the Funeral Direct 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058960 December 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saima Khawaja, 11119 Rockville Pike Ste 100, Rockville, MD 20852 31. Date filed (Month, Day, Year) DEC 1 4 2005 32. Registrar's Signature State Registrar

05-08001 CT Please Type or Print in Black Indelible Ink. Ensure A	AIL-Copies A	re Legible.	
Quentin Antonio Bryant Unpend Items: 23a, 27, 28a, b, C, d, e, f per MEURO. State of Maryland / Department of Health and 1- State Registrar Certificate of Death		ene 2005 402	76
1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 2005 10:1	
Medical quentin Anionio 1579ani		27 2005 10:10 4c. County of Death	O A™
3002 Thornedale Avenue Apartment 5 Baltimore		N/A	
Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min Usual Residence of Decedent		(ear) 9. Birthplace (State or Country) 1978 May lav	
10a. State 10b. County 10c. City, Town or Location		10d. Inside Cit	
Too. Street and Number 10e. Street and Number 10f. Zip Code	1100	1 Dives	2 No
10e. Street and Number 10e. Street and Number 10f. Zip Code 21215		USA.	
10a. State 10b. County 10c. City, Town or Location 10b. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10d. Zip Code 11. Marital Status 11. Mar	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
10a. State 10b. County 10c. City, Town or Location What Pacific May 10c. City, Town or Location 10c. City, Town or Location 10d. Zip Code 11d. Zip Code 11d. Was Decedent Ever in U.S. Armed Forces? 1	orking	Sb. Kind of Business/Industry	
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Co. Mythod of Disposition 20h Place of Disposition (Name of	Ave ARTS.		5
E 25 2 4 Donation 5 Other (Specify) Ne Bay View Dec	8,2005 B	Saltimore, MD	
20a. Method of Disposition 1 Burial 2 Deremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) Me Bay View 20 Name and Address of Facility Ronald Whay Condign 4 Grant	Ayson Fu	neral Home , Balti: Md 21:	201
Physician [Medical] 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Diffuse Pulmonary Microembolism disease or condition resulting in death) Due to (or as a consequence of):	ac or respiratory arres	it, Approximati Interval Bet Onset and I	ween
Sequentially list conditions. if any, leading to immediate cause. Either Underlying b. Due to (or as a consequence of):			
E Cause (Disease or Injury c.			
dical			
Due to (or as a consequence of): Continue		23d. Date of delivery Month Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of c	
should sh	24a. Was an	24b Were autopsy findings	available
The lar The lar lar lar lar lar lar lar lar lar lar	autopsy performe	ed? death?	ause of
25. Was case referred to medical examiner? 1	eath (Check only one,		
Hospital: 1 Inpatient 2 FVOutpatient 3 DOA Other: 4 Nursing	Home 5 Residen	ice <u>(MD</u> Other <i>(Specify)</i> SCET v injury occurred	ne
27. Manner of Death 1 Natural 2 Accident 3 Suicide 3 Suicide 28a. Date of Injury 28b. Time of PTC 28c. Injury at Work? 11/27/05 10:00 A.M 1 Yes 2 No. 28a. Date of Injury 11/27/05 10:00 A.M 1 Yes 2 No. 28a. Place of Injury 28b. Time of PTC 28c. Injury at Work? 11/27/05 10:00 A.M 1 Yes 2 No.	Unknown		
The part of the pa		oet and Number of Rural Route Num State) 3002 Thornda More, Md.	le Av
29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla one and manner stated.	ace, and due to the cau courred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s	s)
The state of the s	29	d. Date signed (Month, Day, Year)	
296. Signature and title of certifier OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND QUB 10 MD 111 Penn Street	N.	ovember 28, 2005	
20 Name and address of causes who completed eaute of death (from 22a) (Time Driet)	11/0		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA PUB 10, HD State Registrar 31. Date filed (Month, Day, Year) DEC 1 4 2005		re, Maryland 2120) 1

			Ficase	State of Marylan		ont of Health and	_	_	•
			1 - For State Registrar	State of Warylan		ate of Death		100 Apr. 0 0 5	10277
			Decedent's Name (First, Middle, La	st)			2. Date of Dea	ith	3. Time of Death
	Physici		Eln	ita	Bether	,	Month	Day Yea	1 1 / / 11
	/Medic Examin		4a. Facility Name (If not institution, giv	·		ity, Town, or Location of Dea		4c. County of D	eath
		. "	Future Care Nu	irsina Home		altimore			
34	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday) If Un Yrs. Mont	der 1 Year If Under 24 Hrs ns Days Hours Min	. (Month, Day	/, Year)	Birthplace (State or Foreign Country) orth Carolina
	p 3		Usual Residence of Decedent 10a. State 10b. County	10c. Cib	y, Town or Location				10d. Inside City Limits
	Maryla f sho	5	Maryland		Baltim	nre			1 PYes 2 □ No
	r 28a-	rect	10e. Street and Number	•		Zip Code		10g. Citizen of What	Country?
	h with	al D	4800 Seton D	rive		21215		usA	
	ems .	iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, Ite Madical Exaction must be notified at or other traumatic avant, Ite Madical Exaction.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		s 2 Se No Specify:		Consider	black
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Decedent's U	Isual Occupation	orkina	16b. Kind of Busine	ss/Industry
21	within ene. than	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		work done during most of wo T use retired)	9	11	
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Maryland	ould be fi Mental H arked ot atic avar	Be		_ •		Curz		Maideir Surriame)	
Z Z	hould d Men marke matic	T _o	William L. 19a. Informant's Name/Relationship (19b. Mailing Addr	ess (Street and Number or R	, ,	r, City or Town, State	e. Zip Code)
<u>≅</u>	nd 2 sho lith and 27 la m r traum		Lena Johnson		2614 Pa	rk Heights -	_	altimore	7
ē,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition	20b. P	lace of Disposition (Name of Strong S	Date	20c. Location - City	or Town, State
Baltimore,	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JRemoval from State	ro Creme	1 100 1 1	5 2005	Baltimor	- Maryland
alti	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lice	ее	22. Name	and address of Facility	Λ.	7	es Funeral Hon
œ	Dep Imp			Land	4611	Park Height	's Ave.	Baltimore	-Md 21215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plication that caused the deat one cause on each line.	h. Do not enter the r	node of dying, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between
15	Physician		Immediate Cause (Final disease or condition	a.	Vascol	an Dement	٤		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq					l
No.	LAGITITIC	_	Sequentially list conditions,	b Due to (or as a conseq	nence of).				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D40 (0) 43 4 00/1304	301130 017.				
ď,	be execuicien and burial-trai	Exar	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):				
760,	0 5 0	Cal	(d					
68	rtifica ng ph as th	Med	IF FEMALE:						
Вох	ith ce itendii	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	I death 3 Ectopi	c pregnancy		23d. Date of Month	delivery Day Year
0.	 requires that the death certifical been signed by the attending phy should be detached for use as th 	Physiclan/Med	1 ☐ Yes 2 ☑ No	4□Pregnant at time of d 9□ Unknown	eath 5 🗌 Other	(specify)			Du, Tou
P.O.	that the	P	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	ng cause given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ds,	uires sign id be	d by					1 🗆 Y	es 25No 3□	Probably 4 Unknown
S		Completed					24a. Was a	an 24b. Were	autopsy findings available
Re	sician: The law certificate has b irector, page 2 s	mo					autop perfor 1 \(\text{Yes}	rmed? death	to completion of cause of 1? /es 2 \sum No
ta	an:] rtifical tor, p	BeC	25. Was case referred to medical			26. Place of De	ath (Check only or		20140
Į ×	Physician: this certificral director, i	To B	examiner? 1 ☐ Yes 2 ☎ No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Resid	lence 6 Other (S	Specify)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sio	Attending r death. actor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	20	М	1 Yes 2 No			
Division of Vital Records,	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined		ome, farm, street, fac y)	tory, office	28f. Location (S City or Tow		Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Diract completely filled in by		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge death occur	red at the time, date and place	and due to the	auco/s) and manner	r an etatod
	24 hc 24 hc Fun etely	Medical		miner: On the basis of examina and manner stated.					
	vithin o the	Me	29b Signature and title of certifier			29c. License number	1	29d. Date signed (Me	onth, Day, Year)
		-	> <	\)	03757	3	December	13,200
Ì	11		30. Name and address of person who	completed cause of death (Iter		-0			
	l		508 RIDELL		and Str	Krotevstan	MD	21136	
1		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature				
	Regist	rar	DEC 1 4	2885	b 1	20			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Year Month **Physician** on Balbina Brubaker 12 2005 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Genesis Multi-Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Days **Funeral** Months 1 □ M 2 XF 87 Yrs. 187-03-7152 May 29, 1918 Pennsylvania Director Usuet Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Marylend nent of Health end Mentel Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a Stete 1 ☐ Yes 2X No Catonsville Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21228 B-56110 Edmondson Avenue, Apt. Funerai 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 XNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify. Š White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Zelinski Edna Leon Jezorek 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Paula C. Snyder, daughter 257 Wakely Terrace 21014 Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State important: If It any injury or 12/09/05 Metro Crematory, Inc. Department Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liounsee Thomas Gregor 22. Name and Address of Fecility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore. 23a. Part1. Enter the discrete, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only be cause on each line. MD 21228 **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical SENSIS Examiner Examiner ASPIRATION PNEUMONI. the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. attending physician end for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical MINTAL STATUS 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probabiy 4 ☐ Unknown You luke þ Division of Vital Records. 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 → 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 FiNetural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier FDeleoco 130 32717 12/09/05 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) TOWSON MB 21204 FERNANDOA DELGADO 7505 OSLER 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State DEC 1 4 2005

Registrar

R. 2000

			For	State of Maryla		artment o			211115	40279
·y			Registrar 1. Decedent's Name (First, Middle, Las	<i>t)</i>	Ce	runcate C	Dealli	2. Date of Dea	teg-No-	3. Time of Death
×	Physici			Claude M	erle	Bramb.	le	DEC	9, 2005	10:30 A ^M
	/Medic Examir		4a. Facility Name (If not institution, give				n, or Location of De		4c. County of Dea	
- 1		ark_	3301 Wallford	Drive			Dunc			ltimore
	Funeral		5. Social Security Number 6. Se	7. Age (In yr:	s. last birthday) 64 Yrs.	If Under 1 Ye Months Da		in. (Month, Day	r, Year) C	rthplace (State or Foreign country)
- 100	Director		216-26-7233 Usual Residence of Decedent		04 113.			AUG 9,	1941 Ma	aryland
	ehow		10a. State 10b. County		City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f	ctor	MD Balı	imore			Dundalk	T		1 ☐ Yes 2 X No
	72 hours after death with the Maryland Insture!; or Heme 23s or 28s-f ehow clost Exeminer mast be nutified at	Director	10e. Street and Number	l Dudasa		10f. Zip Cod			10g. Citizen of What C	country?
	es 23s	era	3301 Wallford	Drive 12. Was Decedent Ever in	11 5 12	Was Doodool	2122		USA	oriogo Indiae
10	r Her d	Ē	1 ☐ Never Married 2 🕅 Marned	Armed Forces? 1 Tyes 2 Tho If Yes, Give A				(Specify Yes or No- erto Rican, etc.)	Black, Wh	
036	raf', o	by	3 Widowed 4 Divorced	If Yes, Give A Year or Dates:		1 □ Yes 2 X	No Specify:		Specify: V	√hite
5-0	72 hours "natural", dical Exp	Completed by Funeral	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Oc kind of work do	ne during most of v	vorking	16b. Kind of Business	s/Industry
121	within ene. then "	E P	Elementary/Secondary (0-12)	College (1-4or 5+)	III e.	DO NOT use re	oenter		Const	ation
d 2	filed Hygid Sther		17. Father's Name (First, Middle, Last)		_	Cal		lame (First, Middle,		cuction
lan	hould be filed id Mental Hygi marked other matic event, u	To Be	Henry (Claude Bra	mble		Haz	zel	Gordo	n
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (T			ng Address (Str			r, City or Town, State,	
Σ,	s 1 and 2 should be filed within 72 hr I Health and Mental Hyglene. Itam 27 is marked other than "natu other traumatic event, the Medical		Calista D. Bran				ford Dri		dalk, MD	21222
Baltimore, Maryland 21215-0036	0 0		20a. Method of Disposition 1 Burial 2 XCremation 3 Di	Removal from State	-	matory or other	place)		20c. Location - City or	
Him			4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License) Me			Inc. 12,		Baltimo	ore, MD
Ba	permit. Departr importa any injt		Sers EM	a Hill		rematic	n Society	y of Maryl	land, Inc.	21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de				ad Baltin		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		netust	atic	lung	Cancer		Onset and Death
3	/Medical		resulting in death)	Due to (or as a conse	equence of):		0			
	Examiner	L	Sequentially list conditions,	b. ————————————————————————————————————						
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or);					
Ć,	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	cDue to (or as a conse	equence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physicien and as should be detached for use as the burial-transit	dlcal		d						
9	ntifica ing ph a as th	Med	IF FEMALE:							
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3[Ectopic pregna			23d. Date of de Month	livery Day Year
0	the de by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of 9□ Unknown	death 5	Other (specify)			,
Δ,	that the phase of		Part II. Other significant conditions co	intributing to death but not re	esulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
of Vital Records,	w requires been sign should be	ed by						1 ½ Y	es 2⊡No 3⊡P	robably 4 ∐Unknown
000	taw reas bee	plet						24a. Was a		utopsy findings available completion of cause of
Ä	The ate h page	Completed						perfor	med? death? 2 No 1 ☐ Yes	
Vita	Physician: Trust certificateral director, p	Be	25. Was case referred to medical examiner?	Hospital:		= 1	Osh	eath Check only or		
o	Phys rat di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2(28a. Date of Injury	ER/Outpatier 28b. Time o	" 3E DOA			ence 6 Other (Spe	ecify)
	Attending I r death. ector: After by the funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		njuryat Work? I∐Yes 2∐No	Est. Boscillo III	ow injury occurred	
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, offi	Сө	28f. Location (S. City or Town	treet and Number or R	ural Route Number,
Ō	Ital or A irs after ral Directed in by	Cer								
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsicien: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in m	e time, date and pla ny opinion, death oc	ice, and due to the c curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	2 -	man	29c. Lic	ense number	2	9d. Date signed (Mon	th, Day, Year)
	/		· /	Jahr	~ ("").	D	54841		December 9	, 2005
	り		30. Name and address of person who co							,
	* *		Ashkan Bahrani, M. 31. Date filed (Month, Day, Year)	D. 9114 Phi		ia Road	, Suite 2	08 Balti	more, MD	21237
	Sta Registr		DEC 1 4 200		he Acra	as a				

			State of					nd Mental Hy		o o e	
			For State Regiatrar		Cei	rtificate of	Death		Reg. No.	005	40280
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Margaret L. Buck	205)		4b. City, Town,	or Location of	Decembe		, 2005 County of Death	10:15 PM
	Examin	er	4a. Facility Name (If not institution, give street and numb Erickson Renaissance Gard			- /-	er Spri		46. 0		
	Funeral		5. Social Security Number 6. Sex 7.		last birthday)	If Under 1 Yea	r If Under 2	4 Hrs. R Date of Bir	th	Montg 9. Birth	place (State or Foreign
	Director		348-14-8584 ¹□M ⅔□F		83 Yrs.	Months Days	Hours	Min. (Month, Da Aug 8,	1922	111	inois
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Aaryla f sho	ō	Maryland Montgomery			ver Spri	no				1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number		DIL	10f. Zip Code	11 <u>g</u>		10g. Citiz	en of What Cou	ntry?
	h with	al Di	3160 Gracefield Road			2	0904			USA	
	ems s	ner	11. Marital Status 12. Was Decede Armed Force	ent Ever in U	l.S. 13.			in? (Specify Yes or No Puerto Rican, etc.))- 1	4. Race - Ameri Black, White,	
36	or It	by Funeral	1 X Never Married 2 ☐ Married 1 ☐ Yes 2			1 ☐ Yes 2 🛣 No				Specify: Whi	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Medicul Exp. A er mest be rightfind at	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Date 15. Decedent's Education	es:	16a, Dece	dent's Usual Occi	upation			d of Business/Ir	
75	nin 72 In "ne Medis	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	lor 5±)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most (ed)	of working			,
212	giene giene er the	mo:	1		Tec	chnician				NSA	
ם	be file ta! Hy d oth	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middle		Sumame)	
<u>Y</u> a	Men Men Marke Marke	2	Frank Buck		401 14-11			ella Colgar		T C1-1- 7'	- 0-4-)
Mai	d 2 st th and 7 ien traun		19a. Informant's Name/Relationship (Type, Print) Betty Brown, Friend		1.	•		or Rural Route Numb			or a constru
	os 1 end 2 of Health a item 27 le other trau		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other pi	LOOK Le	ane Laurel,		Y LANCE Z ation - City or T	
OE .	Pages ent of nt: if i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	216		rematory or ouner pi		12/12/05	Bal:	timore	Maryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. Livet must be notified at once.		21. Signature of Funeral ServicerLicensee	'	25	Name and Add	ress of Facility				
<u> </u>	88 2 8		Thomas Gregor			299 Fred	erick R	ety Of Mary Road Baltin	ore,	Maryla	nd 21228
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on accomplications.	ised the deat th line.	th. De not en	the mode of dy	ing, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		Duy to los	as a consec	quence of):	10, 11	cider	4			All 1
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or	b. Due to (or as a consequence of):							May
4	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			/				MI	
Ö,	te be executed ysician and e burial-transit		resulting in death) Last Due to (or	as a consec	quence of):						
8760,		dicai	d								
89 x	The law requires that the death certifica ste has been signed by the attending phrage 2 should be detached for use as the	/Med	IF FEMALE: 23c. If yes, outcome	ome of pregn	ancv				2.	3d. Date of deliv	an/
Вох	atten after of for u	Physician/M	in the past 12 months?	h 2 ☐ Feta nt at time of c	al death 3	☐Ectopic pregnan☐ Other (specify)				Month	Day Year
P.O.	t the c by the achec	hysi	9 ☐ Unknown 9 ☐ Unknow	/n							-
	es tha igned l be det	by P	Part II. Other significant conditions contributing to dea	th but not res	sulting in the u	nderlying cause o	jiven in Part I.				he cause of death?
Records,	v requires been sign should be	ted						1 🗆	Yes 2L	Prof	bably 4 □Unknown
ec	ne law r n has be ge 2 sh	Completed						24a. Was		24b. Were auto prior to co death?	opsy findings available empletion of cause of
al F	i: The							1 ☐ Yes	2 040	1 Yes	2 □ No
Vital	Physicien: r this certific ral director,) Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inp] ER/Outpatier	2C DOA C		of Death (Check only of Sing Home 5 ☐ Resi		Cother (Coord	4.1
o	y Phy er this	n: To	27. Manner of Death 28a. Date of	Injury	28b. Time o			28d. Describe			197)
ion	Attending r death. actor: After	atlo	2 Accident investigation	Day Year)	Injury		∃Yes 2⊟N	lo			
Division	i or Atte after de Diracto I in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place o building	f Injury - At h j, etc. <i>(Speci</i>	nome, farm, st	reet, factory, offic	9	28f. Location (City or To		Number or Run	al Route Number,
	urs af erai D							<u> </u>			
	the Hospitel or hin 24 hours after the Funeral Dir npletely filled in	Medical	29a. Certifier (Check only one) 15 Certifying Physician: To the base and manne	is of examina r stated.	ation and/or in	vestigation, in my	opinion, death	n occurred at the time,	date and p	olace, and due t	o the cause(s)
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	11		29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
	-		Muller Mest	7		Door	1337	5	12/1	2/05	-
	O,		30. Name and address of person who completed cause	of death (Iter	т 23а Туре,	Print)	10 7	a. II			
	\		31. Date filed (Month, Day, Year) 32. Reg	all LV1	EL OF	KING N	(1) 20	704			
	Sta Registr		DEC 1 4 2005	ABD A	A	29c. Lice DOUS					

			1 - For State Registrar	State of Maryland	d / Departme		Mental Hygie	ne 2005	40281
	Physici /Medi	cal	Decedent's Name (First, Middle, Last) BEN 4a. Facility Name (If not institution, give s	treat and number)	BARBER	ity, Town, or Location of Death	2. Date of Death Month De Gem		205 450 AM
Sel	Examir Funeral	ner	Sin ai Hospita 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	rest birthday) If Uni	Ballown, or Location of Death Ballown Ove der 1 Year If Under 24 Hrs. ns Days Hours Min.		4c. County of Dea	N/A rthplace (State or Foreign country)
Barber	Director		060-40-0030 X Usual Residence of Decedent 10a. State 10b. County	M 2 F 65	Yrs. Town or Location	S Days Hours Hills	8. Date of Birth (Month, Day, Ye AUG. 29, 1	940	I SRAEL 10d. Inside City Limits
sen	with the Maryland a or 28e-f ehow	irector	PA BUC	KS RIO		NORTHAMPTONTON Zip Code		Citizen of What C	1 √Yes 2 No
B	death with ms 23a or	erai D		OAD 2. Was Decedent Ever in U.S	12 140- D	18954	To a Maria	US 14. Race - Am	
7 025	172 hours after death with "netural", or Items 23a oi idical Exam net must be	Completed by Funeral Director	11. Marital Status 1 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert s 2 X No Specify:	o Rican, etc.)	Black, Wh	
tient Khaun a Maryland 21215-0036	within 72 h iene. than "netu	ompietec	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	life. DO NOT	work done during most of wor	king	D. Kind of Business	s/Industry
10 P	other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Mai	den Sumame)	
tient Marylar	2 should by and Menta is marked	٩	YECHTAEL 19a. Informant's Name/Relationship (Type	ne, Print)	BARBER 19b. Mailing Addre	RACHEL ess (Street and Number or Ru	iral Route Number, C		DOLINSKY Zip Code)
S, M	s 1 and 2 should if Health and Mer Item 27 is mark other traumatic		The state of the s	IFE COLUMN	The second secon	YNFORD ROAD -	RICHBORO,		
To anomalous			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Re 4 ☐ Donation 5 ☐ Other (Specify)	.00	ace of Disposition (<i>fi</i> metery, crematory of AT SHOIII	or other place) CEMETERY 12/1		c. Location - City o FI ΔVTV	
\mathcal{R} Baltimore,	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service License		1		L LEVINSO		
	40200		23a. Parn. Enter the disease, or complic shock or heart failure. List only on	ations that caused the death.		REISTERSTOWN node of dying, such as cardiac	ROAD - PI or respiratory arrest,	KESVILLE	Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	Pancrea					Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ	ence of):	d			Zidan
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (r as a conseque	ence of):				
,0	be execu icien and burial-tra		that initiated events c. resulting in death) Last	Due to (or as a consequent	ence of):				
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P.O. Box	The law requires that the death certificate be executed te has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□Ectopic	c pregnancy (specify)		23d. Date of de Month	olivery Day Year
	res that the signed by be detaction		Part II. Other significant conditions conf	inbuting to death but not resul	lting in the underlyin	g cause given in Part I.	23e. Did tobac		o the cause of death?
ord	w require been si should i	Completed by	prostate cance	25			1 Tyes		robably 4 Unknown
Rec	The lav	ошо	CARROLL STON	tem dinon	ne		24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
Vita	slcian: certific rector,	Be	25. Was case referred to medical examiner?	ospital:		Other	th Check only one		
o o	ding Phys h. After this funeral di	on: To	1 Yes 2 No Pt 27. Manne of Death 1 Natural 5 Pending	1 X Inpatient 2 L	R/Outpatient 3 28b. Time of Injury	DOA 4 Nursing H 28c. Injury at Work?	ome 5 Residence 28d. Describe how		ecify)
Division of Vital Records,	or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	M ne, farm, street, fact	1 Yes 2 No	28f. Location (Stree City or Town, S		lural Route Number,
J	To the Hospital or Attending within 24 hours after death To the Funeral Directors completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	rledge, death occurr on and/or investigati	ed at the time, date and place ion, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	vithii Toth	X	29b. Signature and title of certifier			29c. License number		Date signed (Mon	
	0/2		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, Print)	KESC Himore 240	000	Decembe	2005 p
	IV		Tatiana Lamia,	Sinai Hospi	tal of Ba	Homore 240	I W Belie	tre ho	Baltimer 1/1/2
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signati	HO B				

			For State Registrar	State of Marylan	-	artment of He		lental Hygie	2005	40282
	Physici		Decedent's Name (First, Middle, Last Alice Elenor	Cuffley				2. Date of Death Dec.	gay 2 ^{Yoar} 5	3. Time of Death 2:45 a M
1	/Medic Examin		4a. Facility Name (If not institution, give		A	4b. City, Town, or Location of Death Joppatown			4c. County of Death Harford	
	Funeral Director			7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 3-6-24	9. Birthp Cour MD	place (State or Foreign ntry)
	Maryland f ahow	tor	Usual Residence of Decedent 10a. State 10b. County MD		y, Town or Lo				1	10d. Inside City Limits 1 ☐ Yes 21 No
	3a or 28a-	Funeral Director	10e. Street and Number 628 Harbosside	Dr. Apt. A		10f. Zip Code 21128			Citizen of What Cour	ntry?
980	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than "natural", or itama 23a or 28a-f ahow avant, ita Medical Exartinar must be notified at		11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	within 72 ho ene. then "natur the Medical.	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 6th		(Give	dent's Usual Occupation of work done du. DO NOT use retired)	ion ring most of worki	ing 16t	. Kind of Business/In	dustry
Maryland 2	be filed Ital Hygi od other avant, I	To Be Co	17. Father's Name (First, Middle, Last) Howard Crawford	1		1	8. Mother's Name	(First, Middle, Maid Cher		
	nd 2 s lith ar 27 is r trau		19a Informant's Name/Relationship (T Charles Ettinge	er (Son)	207	Kerria L			ity or Town, State, Zip er, MD 21	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item any Injury or othe once.		20a. Method of Disposition 1 ⊠ Buriai 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify) 21. Signature of uperal Sylice Licen	Removal from State Cro	emetery, crer WNSVi	2. Name and Address	12-9-	-05 An	ne Arund	el Co. Fh
	80F#9		23a. Part1. Enter the disease or comp shock, or heart failure. List only of	elications that caused the death					Md 2123	Approximate Interval Between
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P.O. Box	at the death certific by the attending p tached for use es t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1							
Records, P.	w requires thet been signed b should be deta	ρ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause given	in Part I.	İ	co use contribute to the	
al Rec	ysician: The law i is certificete hes bi director, page 2 st	Completed						24a. Was an autopsy performed 1 Yes 2 M	prior to co	psy findings available mpletion of cause of
Vital	Physician: this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpatier			(Check only one)	e 6 □Other (Specif	
ion of	Jing Ph J. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury a Work?	at :	28d. Describe how i		7
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify	v)			City or Town, S		
	tha Hosp nin 24 hou tha Fune npletely fi	Medical	(Check only 2 Medical Exam	vician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in my opir	nion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	o o o o		29b Signature and title of certifier Crack M. J.	haughness,	y	29c. License			Date signed (Month,	•
1	2		30. Name and address of person who de RN/15-514 QU(6/1) 31. Date filed (Month, Qay, Year)	complete deuse of death (It in 1965) 32. Registrar's Signa		LIMTRE!	ERP B	CLAIR.	JA015	1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Da 2005 **Physician** December (3 McCall L. Carson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) GIO BANE
If Under 1 Year If Under 24 Hrs. ARINGE 8. Date of Birth (Month, Day, Year) FEB 9, 1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1**∑**M 2□ F 89 Arkansas Director 513-01-0462 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Example must be notified at Anne Arundel Glen Burnie 1 ☐ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 7975 Crain Highway, Apt. 118 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WW If Yes, Give Year or Dates: Kor 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status WW II 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Korea White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Soldier US Army 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 Is marked ofth any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) Rebecca Carson Anna Bright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 224 Stauffer Ct. Patricia S. Manuel, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/13/05 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart ongestive **Physician** /Medical Que to (or as a consequence of): Examiner enal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and the burial-transit Due to (or as a consequence of) certificate be Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has r this certificate has aral director, page 2 performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire ö Hospital 1 🕇 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 13, 20 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) : tal Drive, Glan Burnie, MD. 21061 500 vale E. W 31. Date filed (Month, Pay, Year) UEC 1 4 2005 32 Registrar's Signature State Registrar

		- State of Marylan 7 State of Marylan Registrar 1. Decedent's Name (First, Middle, Last)	d / Depa 2-14-0 Cer	adment of 5 tas tificate of	Health a Death	and M	2. Date of De		05	1: 0 2 8 L
Physicia /Medic Examine	al -	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center	5	4b. City, Town,			mo	_	o'S hty of Death	4:25 PM
Funeral Director		5. Social Security Number 220-38-9784 6. Sex 1 M 2 N F 64 65 Usual Residence of Decedent	last birthday) Yrs.	If Under 1 Yea Months Day	r If Under	24 Hrs. Min.	8. Date of Bi 11/05/2	149741)	9. Birthp Coul	place (State or Foreign ntry) MD
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within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Exercities must be notified at	Completed by Funeral Director	116 STRONGWOOD ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:	1	21117 Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:			ocify Yes or No Rican, etc.)	o- 14. F	S.A. Race - Americ Black, White, city: WHI	etc.
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ould be file Mental Hy tarked oth tatic event	To Be (17. Father's Name (First, Middle, Last) HENRY 19a. Informant's Name/Relationship (Type, Print)	DANI	ELS	MI	LDRE)	, Maiden Sun	E	BELL
permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itsm 27 is marked other then "natural", or items 23s or 28s-f show sny injury or other traumatic event. It a Medical Examinar must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo emetery, cren B SHAL	STRONGW esition (Name of matory or other p OM MEMO 2. Name and Add 8900 REI	RIAL 1	2/13, y SO	eate /2005 L LEVII	20c. Location REISTE	RSTOWN BROS	own, State
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To the Hospitel or A within 24 hours after To the Funeral Direcompletely filled in b	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examina and manner stated. 29b. Signature and atte of certifier	wledge, death tion and/or in	vestigation, in my	time, date any opinion, dea	nd place, a	and due to the	date and place 29d. Date sign	e, and due to	Day, Year)
N 3 - 3 - 8	2	30. Name and address of person who completed cause of death (Item	n 23a) (Type,	De	5056	7				s n ₁ md 2
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signal	iture	So IV	ain	>1	44 EX	e ev	Heri	n mos

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			1 - State Registrar	tate of Maryl	and / Depa	artment of F	lealth and N	Mental Hy) <u> </u>	40285
	Physici /Modi:		1. Decedent's Name (First, Middle, Last) Doris E Dukes					2. Date of De Decemb		2005	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give stree Ridgeway Manor Nurs:			4b. City, Town, o	Location of Death		4c. Co	ounty of Death	
	Funeral Director		5. Social Security Number 6. Sex 212−18−9982 1□ M	7. Age (In	yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 1	th 17. Year) 2, 192		lace (State or Foreign try) Land
	land bw		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				1	0d. Inside City Limits
	the Mary 28a-f sh	ector	MD Baltimore		Catonsvi	11e			10a Citica		1 ☐ Yes 2 ♣ No
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9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important; if item 27 is marked other then "natural", or items 23a or 28a-f show important; if item 27 is marked other then "natural", or items 23a or 28a-f show important if item 27 is marked other transities round an once.	d by Funeral Director	11. Marital Status 12.	Was Decedent Ever Armed Forces? I ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.))- 14.	ed Stat Race - Americ Black, White, pecify:	an Indian,
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	tand 2 sho Heelth and I tem 27 is me		19a. Informant's Name/Relationship (Type, Brian Allen Dukes /				and Number or Rur ve Catons				
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P.O. Box 68	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	f yes, outcome of pre 1□Live birth 2□I 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive	ry Day Year
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Division	To the Hospitel or Attending Physician: The lav within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - building, etc. (Sp	At home, farm, str eecify)		Yes 2□No	28f. Location (S City or Tov	Street and N vn. State)	lumber or Rura	l Route Number,
	the Hospi in 24 hount he Funer pletely fills	Medicai	29a. Certifier 1 certifying Physicia (Check only one) 1 Medical Examiner:	n: To the best of my On the basis of exar and manner stated.	knowledge, death nination and/or in	estigation, in my o	pinion, death occur	and due to the red at the time,	cause(s) an	d manner as st ace, and due to	ated. the cause(s)
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1	1		30. Name and address of person who complete Courants HC			Print)	8 6km B.			g - 200!	
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	Physici	an	Decedent's Name (First, Middle, Las. JOHN JOSEPH	DILLMAN				2	Date of Death	Day Yea	1660111
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)	/ -	4b. City, Town,	or Location of D	Death	12-	4c. County of De	eath
, i	Funeral		Social Security Number	Kt65 pi fec/ Cent x 7. Age (In yis XM 2□ F	() () () () () () () () () () () () () () (Hrs. 8	Date of Birth (Month, Day, 2-8-193	Baltin Year) 9. E	Inthplace (State or Foreign Country)
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	the Marylan 28a-f ehow patified at	or	10a. State 10b. County MD BALT	IMORE 10c. C	ity, Town or Lo	ROSEDA	LE				10d. Inside City Limits 1 ☐ Yes 2 XNo
	or 28a-1	Funeral Director	10e. Street and Number			10f. Zip Code			10	g. Citizen ol What	Country?
	leath w	erai	8101 WOODHAVEN R	OAD 12. Was Decedent Ever in I	U.S. 13 1		21237	2 (Speci	fy Vas or No-		S.A.
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Maryland		To Be (17. Father's Name (First, Middle, Last) BERNARD	OILLMAN			18. Mother's	,		laiden Sumame) ITH)	
	r 23 Had		19a. Informant's Name/Relationship (T)	vpe, Print) DAUGHTER	4	ng Address (Stree CHARMUTH			Route Number, OPPA TO W	City or Town, State	, Zip Code) 21085
Baltimore,	Pages 1 annent of Hearint: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	20b. Removal from State	Place of Dispo cemetery, cren	sition (Name of matory or other pla	300)	Dat		Oc. Location - City	or Town, State
altim (크린란증	1	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	1 8 44		EMATORY Name and Addr				CATONSVII ALE FUNEF	
ä	Depa Impo eny ii		23a. Part1. Enter the disease, or comp			1211 CHE	SACO AVI	ENUE	ROSE	DALE, MD	21237
8760,	Physician /Medical Examiner physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien are physician at the physicien and physicien are physician phy	licai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	ackes squence of):		, a tare	tion			Onset and Death
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and hage 2 should be detached for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnand Other (specify)	;y			23d. Date of d Month	elivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause g	ven in Part I.		23e. Did toba		to the cause of death? Probably 4 □Unknown
I Recc		Completed	COPD					_	24a. Was an autopsy perform	ed? prior to death?	autopsy findings available completion of cause of
Vita	iysician: Th	Be	25. Was case referred to medical examiner?	Hospital:		- lot			Check only one		
Division of Vital Records,	ng Pt áter tř ineral	ation: To	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time ol Injury	28c. Inju	4 [] NUISII			ice 6 Other (Sp v injury occurred	ecify)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)	eet, factory, office		28f	Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	Hospi 24 hou Fune etely fii	dicai	(Check only 21 Magical Exami	sician. To the best of my kin iner: On the basis of examin- and manner stated.	ation and/or inv	actination in my	aninion death a	courrad	at the time det	a and alone and di-	- 4- 40 / - 1
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licen	se number		29	d. Date signed (Mor	nth, Day, Year)
	17	/	30. Not and address of person who co	and manner stated. completed cause of death (Ite	m 23a) (Type	Print)	3643	0		12/3/03	
_	U		JESFREY JZICH	trastan >	10	2112 0	valal	k,	Ba	lt, more	21225
	Sta Registr		31. Date filed (Month), Day, Year) DEC 1 4 2005	32. Registrar's Sign	ature	W.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** LILLIAN DEMBECK December 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner oseda Sq vare Pite 405 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 □ M 2X F 86 Yrs Director 212-18-0089 12-9-1919 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director BALTIMORE ROSEDALE 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify WHITE 16b. Kind of Business/Industry BALTIMORE CITY SCHOOL 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEDALE, MD 21237 20c. Location - City or Town, State ELKRIDGE, MARYLAND 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21237 ROSEDALE, MD 23a. Part 1. Entre the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1-2 HOURS OVER 101 CARDIDYASCULAR DISEASE 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Pes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? t ☐ Yes 2 ☐ No 2 🗓 **X**0 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 7.8 per fh g850 12-30-05 vt.

			1- For State of Maryland		artment of H				(C) 1788	. —
			Decedent's Name (First, Middle, Last)		imodio oi i	- Journ	2. Date of De.	Reg. Nø.	45-	3. Time of Death
	Physici		Genevieve Engles				Month Dec	Day 11	2005	1:41 a M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D			unty of Death	7. 11 a
	Examir	iệr	30 Locust Street				outi			
	F	Nº I	5. Social Security Number 6. Sex 7. Age (In yrs. la	st hirthday)	If Under 1 Year	inster	Hrs. 8. Date of Birt	-101/	arroll	place (State or Foreign
*	Funeral Director	ŀ	217-14-2548 1□M 2XIF 88	89 Yrs.	Months Days		Jan 26	y, Year)	Cour	ntry)
			Usual Residence of Decedent				Jaii 20,	1917	Mary	yland
	/lanc		10a. State 10b. County 10c. City,	Town or Lo	cation				1	Od. Inside City Limits
	Man, f ah	tō	Maryland Carroll	Wes	tminster					1 ☐ Yes 2 X No
	1 the	rec	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cour	ntry?
	3E o	0	30 Locust Street		21157			Unite	ed Stat	-es
	ms 2	era	11. Marital Status 12. Was Decedent Ever in U.S	. 13.1		ispanic Origin	? (Specify Yes or No uerto Rican, etc.)		Race - Americ	
(0	r Ite	Fur	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1			uerto Rican, etc.)		Black, White,	
93	urs a	by	3 ☐ Vidowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spe	ecify: Wh	ite
21215-0036	72 hours after death with the Maryland Inatural', or Items 23s or 28s-f ahow dieal Examirer rust be notified at	Completed by Funeral Director	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind o	of Business/Ind	dustry
21.5	Pin 7	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	uring most or !)	working			
21	d wit	тo	12	Н	omemaker				Own Ho	ome
	othe othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Sun		
<u>a</u>	Ald b Aents rked tic e	To E	John Baker			N	Mamie Durk	in		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Items 23s or 28a-f ahow any injury or other traumatic event, if a Midical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number of	r Rural Route Numbe	r, City or To	wn, State, Zip	Code)
	alth a		Grace Engles / Daughter	30 1	Locust St	reet, V	Westminste	r, Mar	ryland	21157
Baltimore,	s 1 a f Hei fram tram othe	1.3	ca	ce of Dispo	sition (Name of natory or other place	Ţ.	Date		on - City or To	
E	Page ent o ht: If y or		1 Mourial 2 Cremation 3 Chemoval from State		n Gardens		2/13/2005	Marri	otterri	110 MD
≣	artm ortar injui		21. Signatur o Funeral Service Licensee			s of Facility F	Hubbard Fu	neral	Home	Inc
B	Depare Impor any ir	-	I Unn Koull				enue, Balt			
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			snock, or heart failure. List only one cause on each line.						A. 10.	Interval Between
}	Physician /Medical		resulting in death)		702 1KO	51146	PULMO	nacy	DINENE	lyen
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Ь		_	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	200 06:						
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8760,	cate be executed physician and the burial-transit	E	bue to (or as a conseque	ince or).						
87	cate the the the the the the the the the t	dlcal	d							
9		Me	IF FEMALE:							
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P.0	d by etacl	by Physician/Me								
Ś	law requires that the death certif as been signed by the attending 2 should be detached for use as		Part II. Other significant conditions contributing to death but not result	ing in the ui	nderlying cause give	an in Part I.	V	_		ne cause of death?
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ď	0 4 0	Eo					perfor	med?	death?	
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical			26. Place of I	Death (Check only o	V		
of Vital	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe		g Home 5 Resid		Other (Specify	()
	ding Phy h. After thi funeral	n: -	(A 4 4 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	8b. Time of	28c. Injury Work	at	28d. Describe h	ow injury oc	curred	
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S	al or Attendii after death. I Diractor: A d in by the fu	iflo	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S	treet and Nu	imber or Rura	I Route Number,
Ö	al or afte I Dir	ert	4 Homicide Solominies building, etc. (Specify)				City or Tow	n, State)		
	spita nours ners		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	edge, death	occurred at the tim	e, date and pl	ace, and due to the	ause(s) and	manner as st	ated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical Examiner: On the basis of examination one) and manner stated.	n and/or inv	estigation, in my op	inion, death o	ccurred at the time, o	date and place	e, and due to	the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier		29c. License	number		29d. Date sig	ned (Month, L	Day, Year)
	^	,	1 - (-, coluis m		19:	3166	\mathcal{O}	12/12	-1200	72
1			30. Name and address of person who completed cause of death (Item 2	(Type	Print			-		
V	7					NPD	AVENTILO	Laco	SMINE	the morning
	Sta	te	31. Date filed (Month, Day, Year) 32. Radistrar's Signatu			0,-	1,1.000		211101	21157
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Physician	ı	Decedent's Name (Eugenio E									_		2. Date Mon 12	of Death th	Day 07	Year 2005	3. Time of 6:40	Death P M
/Medical Examiner	_	a. Facility Name (If n	ot institution,	give str	eet and nu	m <i>ber)</i>			4b. City	, Town, o	r Location	of Death				inty of Death	0.40	1
		Potomac Va	11ey	Nurs	ing H	ome			Roc	kvil	le				Mont	gomery	•	
Funeral Director		5. Social Security Num 578-64-926	3	6. Sex	A 2□F	7. Age (In	n yrs. la:	st birthday) Yrs.	If Unde Months	Days	If Unde Hours	Min.	8. Date (Mor	of Birth oth, Day, 1	70 <i>ar)</i> 931	9. Birthp Cour Chil	place (State on htry) .e	or Foreign
land ow	-	Jsual Residence of D 10a. State 1	0b. County			10	c. City,	Town or Lo	cation							1	0d. Inside C	ity Limits
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "netural", or Items 23a or 28a-f show ont, the then "netural", or Items 20a or 28a-f show ont, the then "netural Example of Example of Funeral Director.			lontgo	mery		(Germ	antow										2 □ No
Min William		10e. Street and Numb		C-i w	-1-					ip Code 874					g. Citizen JSA	of What Cour	ntry?	
ms 23	-	19345 Hott	inger		. Was Dec	edent Eve	r in U.S.	. 13.			lispanic O	rigin? (Spo	ecify Yes			Race - Americ	an Indian.	
ariment of Health and Mental Hygiens "netural", or flems 23a or 28a-f show ortant: If item 27 is marked other than "netural", or flems 23a or 28a-f show injury or other treumatic event, the Maxical Examinational be neithfied at a.g. To Be Completed by Funeral Director		1 Never Married	- ·		Armed For 1 Tyes If Yes, Gir Year or D	rces? 20 No			If Yes, spi			n, Puerto V: Un K			1	Black, White, ecify: whi	etc.	
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Department of Health and Mental Hygiene. Important: If item 27 Is marked other then any injury or other freumatic event, IIIs M ance. To Be Compl		17. Father's Name (Fi Enrique Es		.ast)								er Iti				cobar		
aith and 27 Is m er freum		^{19a. informant's Nam} Victoria I			_										-	wn, State, Zip MD 208		
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Department Important: If any injury or once.	-	` 4 □ Donation 5 21. Signature of Fune			·											ille, 20975 ⁱ		rvice
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en signed to		Part II. Other significa	ant condition	ns contri	ibuting to d	eath but no	ot result	ting in the u	nderlying	cause giv	en in Part	l.	23e		cco use c	ontribute to th		leath?
cate has been s page 2 should													24a	. Was an autopsy performe		b. Were auto prior to cor death? 1 🗆 Yes	npletion of c	available ause of
certifi rector	1	25. Was case referred examiner?	,	Hos	spital:					Oth Oth		ce of Death						
After this certificate has funeral director, page 2			5 Pending		28a. Date (Mon			R/Outpatier 28b. Time o Injury		28c. Injun Wor	y at				ce 6 🗆	Other (Specify	/)	
within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification:		2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6 Could n determi	ot be	28e. Płace build	of Injury - ing, etc. (S	- At hom Specify)	ne, farm, str			103 20		28f. Loca City	ition (Stre or Town,	et and Nu State)	mber or Rura	I Route Num	ber,
n 24 hours he Funerel pletely fille edical C		29a. Certifier 1 (Check only one)	Certifying Medicel E	g Physic	r: On the b	best of m asis of exa ner stated	aminatio	ledge, deat on and/or in	h occurred vestigation	d at the tin	ne, date a pinion, de	ath occurr	and due ed at the	to the cau time, date	se(s) and o and plac	manner as st ce, and due to	ated. the cause(s)
within To the compl		29b. Signature and tit	le of certifier		20	_	Q		29	c. Licens						ned (Month,	Day, Year)	
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State Registrar	4		1 A 2	Ant		- Giariai s	Jigiratu											

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			For Stata Registrar	S	State of	Maryla	nd / Depa	artment of rtificate of	Health ar Death	nd Me		gien e () ()5	40292
3	14.		1. Decedent's Name (First, Mich.	10. (45)	/		TRA	120	50 K	_ 2	. Date of Dea	ith	Vaar	3. Time of Death
	Physici /Medio		[] [] H	KY			F	-DF	-	1000	Month 2	06	2002	5 0610 AM
	Examin		4a. Facility Name (If not instituti	- "		ber)		4b. City, Town,		Death		4c. Count	of Death	h
4	3		Bon Secours					Balti		411				
	uneral		5. Social Security Number	6. Sex 1 ☐ M	1 2 ⊠ F 7		. last birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day	r, Year)	Co	nplace (State or Foreign untry)
	irector		212-23-3345 Usual Residence of Decedent			89	113.				12 1	9 15		VA
yland	MOM		10a. State 10b. Count	У		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
Ma	E S	tor	MD	ΙA		Ва	ltimo	ce :						XXYes 2 □ No
th the	or 28.	Director	10e. Street and Number					10f. Zip Code				10g. Citizen of	What Co	untry?
th Wi	23a	ai	612 Reservo	ir St	reet			2	1217			U.S	5 • A •	
r dea	E E	Funerai	11. Marital Status	12.	Armed Ford		J.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Origii ban, Mexican,	in? (Speci Puerto Ric	fy Yes or No- can, etc.)	14. Ra	ce - Amer	ncan Indian, a. etc.
s afte	o E	by Fu	1 Never Married 2 Ma		1 ☐ Yes If Yes, Give			1□Yes 2XNo				Specia		lack
IIIG Z IZ IS-UUSO be filed within 72 hours after death with the Maryland	ture A fr	pe pe	3 Widowed 4 Divorce	nt's Educati	Year or Dat	es:	16a Dagg	dent's Usuaf Occu	nation			10h Kind of B		land out to
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with A	than	E	Efementary/Secondary (0-12) N/A		Colfege (1-4	4or 5+)	Ur	employ	ed			Unen	plo	ved
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2 should	Department of result and western regions. Department of result and western regions. Proportional: If them 27 is marked other than "naturel; or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at 200s.		19a. Informant's Name/Refation	ship (Type,	Print)			ng Address (Stree						
and and	n 27		Juanita Boyd	-Care	Pro	vider	612	Reserv	oir S	tree	t, Ba	lto, N	1d	21217
2 5	i ot ot		20a. Method of Disposition 1 ☑8urial 2 ☐ Cremation	3 □Rem	oval from S		Place of Dispo cemetery, crea	sition (Name of natory or other pla	ace)	Dat	ө	20c. Location	- City or 1	Town, State
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Dalling permit. Pages	mport any in		21. Signature of Funeral Service	Licensee	- K	D.	, Mã	Name and Add	H West	t				01015
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			23a. Part 1. Enter the disease, shock, or heart taifure. Lis	it only one of	tions that car cause on ear	used the dea chiline.	nth) Do not ent	er the mode of dy	ing, such as ca	ardiac or r	espiratory arr	rest,	-	Approximate Interval Between Onset and Death
Acres 100 and 100 areas	sician		fmmediate Cause (Final disease or condition resulting in death)	_ a		JK	esp.	forly						Oriset and Death
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petr	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<			ACI	11) /	Mar	al low	120		
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v. ≋ E	igned bed	þ	Part If. Other significant condit	1 -	. /		sulting in fhe u	nderlying cause g	ven in Part I.					the cause of death?
Ords, requires t	een s hould	ted		(V)	net		240				1 L Y	es 2□No	3 Pro	obably 4 Unkhown
a w	hesb e2sl	Completed		7	124	Shor	le				24a. Was a autops	SV	prior to c	topsy findings available ompletion of cause of
# ::	pag.	S									perform 1 Yes	med? 2 13 MG	deafh?	218NO
Physician:	ector	Be	25. Was case referred to medic examiner?	al Hosp	nital:			0	h		Check only or		/	
2 4	this rail dir	-T	10 Ye's 2 No 27. Manner of Death		28a. Date of	/	28b. Time of	I JUDON				ence 6 Oth		eify)
oding 4	After	ation:	1 □ Natural 5 □ Pend		(Month	Day Year)	Injury	Wo	ork?]Yes 2 □ No		J. Describe III	ow injuly occur	red	
Atten	ctor: y the	fica	3 ☐ Suicide	I not be	28e. Place o	f Injury - At h	nome, farm, str	eet, factory, office			Location (S	treet and Numl	er or Ru	ral Route Number,
	d in b	Certific	4 Homicide	mined	building	g, etc. (Spec	ity)	,,			City or Town	n, State)		21 / 10310 / 131150.
To the Hospital or Attending	whiting a rous area beaution of the contribute has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1☐ Certify	ing Physici	ian: To the b	est of my kn	owledge, deatl	occurred at the t	ime, date and	place, and	d due to the c	ause(s) and m	anner as	stated.
He He	he Fu	Medical	(Check only 2 Medica	I Examiner:	On the bas	is of examin	ation and/or in	vestigation, in my	opinion, death	occurred	at the time, d	late and place,	and due	to the cause(s)
Tot	Tot	Σ	29b. Signature and title of certif	er				29c. Licen	se number	_	2	9d. Date signe	d (Month	, Day, Year)
			Lahmu	1 (JOSE	M		100	4752	-9		12/6	2/0	6
	1		30. Name and address of perso	who comp	oleted cause	of death (Ite	m 23a) (Type,	Print)	A D	1-	. 0	2/222		
			MUTTON Ja	19861	1 / /	140 [N - (31)	THORE C	11 11	m,	MI Z	(12 1)		
	Sta Registr	_	31. Date filed (Month, Day, Yea DFC 1	4 200!	5 32.	gisfrar's Sign	M. A	29c. Licen 1)00						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1^{Day} , DEC Month 2**00**5 **Physician** 8:10 A M Filadelfia Joseph J. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 21-A Mopec Circle | Houder 1 Year | Hours | Min. | S. Date of Birth (Month, Day, Year) | June 3, 192 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F 215-18-9410 84 Yrs. Marvland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rai', or items 23a or 28a-f show Exercises must be notified at 1 ☐ Yes 2X No Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 21-A Mopec Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If itsm 27 is marked other than "natural", or iter ary or other traumatic svent, the Medical Example. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Industry 12 Butcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manuli Filadelfia Rosa Angelo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If itsm 27 is sny injury or other trauonce. Phillip W. Breece, nephew 2319 East Churchville Rd. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/13/05 Baltimore, MD MacNabb 22 Name and Address of Fagility Cremation Society of Maryland, 299 Frederick Road Baltimore, George 21. Signature of Funeral Service Licensee 820 3 MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advit failure mankles **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Emphysema autopsy performed? certificate 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death Director: After Injury 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12/12/05 D31795 0 Luch Zown Tolvel POD Svite 208 4 wiends 1410152 5601 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Market State of Market State of Market State Amend Item 18 per fh	aryland / Depa 850 12-14-	artment of Hea 05 tas tificate of De	Ith and Menta	al Hygiene	005 4	0294
	Physicia	an	1. Decedent's Name (First, Middle, Last)	10 D.V		M	ite of Death onth Da	a di man gara	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	nov	4b. City, Town, or Loc		cember 40	County of Peath	1295 P'''
			North Klest Hospi	tal	Kandal If Under 1 Year If	Under 24 Hrs. 8. Da	n		nore
	Funeral Director			e (In yrs. last birthday) 56 Yrs.		ours Min. 01	te of Birth onth Day Year 01/1949	9. Bittipi Coun	ace (State or Foreign try) BELARUS
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10	Od. Inside City Limits
	e-f ehc	ctor	MD BALTIMORE	REISTERS	STOWN				1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Coun	try?
	death	Funerai	805 SUBURBIAN ROAD 11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	21136 Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Specify Y	es or No-	U.S.A.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If Item 27 is marked other then "natural", or Items 23a or 28s-f show sayl injury or other treumatic event, the Medical Examinar must be notified at once.	þ	1 ☐ Never Married 2 [Married 1 ☐ Yes 2 [7] If Yes, Give 1 ☐ Year or Dates:	No	1□Yes 2⊠ No Sp	pecify:		Black, White, e	TE
715-	in 72 lin in "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	g most of working	16b. k	(ind of Business/Ind	ustry
21	filed with Hygiene other the		5	CERTI	FIED MEDICI			EDICINE	
and	id be fil ental H ked otl ic even	То Ве	17. Father's Name (First, Middle, Last) RUVIN	GO	LDIN 18.	Mother's Name (First			TZNELSON
ary	2 should and Men ie marke eumatic	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and I	Number or Rural Rout	e Number, City	or Town, State, Zip	Code)
	1 and Health em 27		SERGEY FILIMONOV / HUSBAND 20a. Method of Disposition	20b. Place of Dispo	SUBURBIAN R sition (Name of	OAD - REIS		N, MD 211	
Baltimore,	tment of I tent: if it		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	BALTIMORE	natory or other place) HEBREW COI	NG 12/13/2	005 REIS	STERSTOWN	, MD
Ba	permit. Departr importe eny inje		21. Signature of Funeral Service Licensee		Name and Address of REISTE			& BROS., ESVILLE.	
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do not ent					Approximate Interval Between Onset and Death
-	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	YEM	holu	5		1 or VS.
	Examiner			a consequence or).)				
-	ted nsit	Examiner	Cause (Disease or injury	a consequence of):					
o	ate be executed hysicien and the burial-transit		that initiated events c. Due to (or as	a consequence of):					
38760	physicist the pr	dicai	d						
Box 6	Attending Physician: The law requires their the death certificate be executed in death. ector: After this certificate has been signed by the attending physicien and ector: After this certificate is should be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1□Live birth		Ectopic pregnancy			23d. Date of delive	
P.O. E	the dea the at ched fo	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 ♥ Unknown		Other (specify)			Month	Day Year
	ss thet gned by se deta	by Ph	Part If. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in	Part I. 2	3e. Did tobacco	use contribute to th	e cause of death?
ord	w require been sign should t	eted					1 □ Yes 2	□No 3□Proba	ably 4 Unknown
Rec	he law e has b ige 2 si	Completed					ta. Was an autopsy performed?	prior to con death?	osy findings available appletion of cause of
ita	ian: T artificat ctor. pa	Be Co	25. Was case referred to medical examiner?		26.	. Place of Death (Che	☐ Yes 2⊠ No ck only one)	1 ∐ Yes	250 No
o C	Physic rthis ce ral dire	မ	1 ☐ Yes 2 No Hospital: 1 Inpatie			Nursing Home 5	☐ Residence)
io	ath. rr: Afte	ation	1 Natural 5 Pending (Month, Da 2 Accident Investigation	y Year) Injury	Work?	2 □ No	0001120 1101111111111111111111111111111	ny occurred	
Division of Vital Records,	5 ± 5 €	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office		cation (Street arty or Town, State	nd Number or Rural e)	Route Number,
	To the Hospitel or within 24 hours after the Funerel Dir completely filled in [Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or in	n occurred at the time, divestigation, in my opinio	late and place, and du in, death occurred at t	e to the cause(s he time, date an	and manner as sta d place, and due to	ited. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1	29c. License nui	mber-	29d. Da	ite signed (Month, L	Day, Year)
			hrufine Kajn	h	6291	2	De	cember	112005
1	y		30. Name and address of person who completed cause of d	leath (Item 23a) (Type,	Print)	OSPITAL	RALL	MIGSTO	112005 WW.IND
*	Sta , Registr			ar's Signature					
DH	MH 17 Rev 1/2		DEC 1 4 2005	ver It to	ad -				
			9	ORIĞİ	NAL				

			1 - State Amend Item 25	State of Marylan per me G850	d / Departme 12- <i>15en¶fic</i> a	nt of Health and en of Death		ene 05	40295
	Physicia		1. Decedent's Name (First, Middle, Last) DARWIN	P	GREE		2. Date of Death Month December	Day Year	3. Time of Death $10^{25} \rho_{\rm M}$
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give st Heartland 5. Social Security Number 6. Sex	reet and number) HOSPICE 7. Age (In yrs. M 2 F 28	4b. Cit	y, Town, or Location of Deal A tons Ville er 1 Year If Under 24 Hrs	8. Date of Birth	4c. County of Deat Balt 9. Birt	th one or Foreign
	tryland thow		Usual Residence of Decedent 10a. State 10b. County		y, Town or Location	21110			10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. Hysiene. Insturat', or Itema 23a or 28a-f show ent, Ite Mudical Examinar must be notified at	Funeral Director	10e. Street and Number	E BRANCH K	D. APT. A TOT. Z	RNIE (ip Code 21060		g. Citizen of What Co	1 ☐ Yes 2 🛣 No ountry?
	ours after death w rai', or itema 23a Examiner must i	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	if Yes, sp	edent of Hispanic Origin? (secify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Z Z J	d within 72 hours giene. rr than "natural", I've Medical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of wo	nrking 1	6b. Kind of Business	/Industry
	should be filed within nd Mental Hygiene. marked other than imatic event, it a M	To Be C	17. Father's Name (First, Middle, Last) ("HARLES") CK	PEEN	18. Mother's Na	me (First, Middle, M		USON
ore, mai	is 1 and 2 soft Health ar item 27 la	0 6	19a. Informant's Name/Relationship (Typ) TERESA SOHNSON 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Re	(MOTHER) 20b. F	7505 FUR Place of Disposition (A cemetery, crematory of	r other place)	RD, APT.A, C	Oc. Location - City or	Town, State
Daltilli	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	GL	1 505FF	and Address of Facility	JR. FUN	ERAL HOL	E, MARYLAND ME DIQIT
	Pnysician :	8 4	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deat e cause on each line.	h. Do not enter the m				Approximate Interval Between Onset and Death
	/Medical Examiner	er	resulting in death) Sequentially list conditions, b.	Due to (or as a conseq	juence of):	ie pulmon	ay dise	ese	159.5
,00,	licate be executed physician and s the burial-transit	cal Examin	Sequentially list conditions, if any, feading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	u-nce of);	spulmonay			15 years
O. BOX 60	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3 □Ectopic			23d. Date of del Month	livery Day Year
, L	uires that the signed by a detaction	b	Part II. Other significant conditions con Fluid retent			g cause given in Part I.		acco use contribute to	o the cause of death?
al necolus,	i: The law rec icate has bee r, page 2 shou	Completed	Shunted hyd				24a. Was an autopsy perform	ed? prior to death? No 1 □ Yes	utopsy findings available completion of cause of
VII	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 2 Yes 2 2 100	ospital: 1 Inpatient 2	☐ER/Outpatient 3☐	Othor	eath <i>(Check only one</i> Home 5 Reside	nce 6 Other (Spe	cify)
IVISION OF	anding Ph lath, or: Atter th	ertification;	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Š	ital or Att irs after de ral Directe	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	fy) 		City or Town		
	te Hosp 24 house te Fune letely fi	edical		ician: To the best of my kno er: On the basis of examina and manner stated.					
	To the To the comp	M	29b. Signature and title of certifier	P	2	29c. License number		d. Date signed (Mont	
Ç			30. Name and address of person who con		m 23a) (Type, Print)	D50714		December	
	Sta		ERIC LEVEY, M 31. Date filed (Month, Day, Year) DEC 1	32. Registrar's Signa	707 N. B	LOADWAY, BA	HTIMORE	MU 2121	75

Darwin Green

			1 - For State Registrar	State o	f Marylar	•	artmen			and M		giene Reg. No:	005	1	0296
	Physici	an	1. Decedent's Name (First, Middle,	-							2. Date of De. Month	Day	Year		Time of Death
	/Media	cal	Betty Joan Gu				45 0%	.		(D 1)	Decemb		0, 200.		5:30 A ^M
	Examin	er	4a. Facility Name (If not institution, 614 Longview 1	•	тоөг)				Location o	or Death		4C.	Balti		
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Birt	th		irthplace (State or Foreign
	Director		220-24-4081	1□M 2∏F	77	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da June 2	2,19	28 Ma	country) ry1ar	nd
	pus A		Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d In	side City Limits
	Manyli 1 eho	ŏ	Maryland Baltin	nore		Catons									☐Yes 2 ☑ No
	r 28a-	rec	10e. Street and Number			Catons	10f. Zip					10g. Citiz	en of What C	country?	
	th with	Funeral Directo	614 Longview D	rive			1	21	228			USA	A		
	eme	Iner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	I.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Race - Arr Black, Wh		dian,
ရှ	s afte	by FL	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Gi	2 (3(No ve		1 ☐ Yes 2		Specify:		,			White	l .
9500-612	filed within 72 hours after death with the Maryland Hygione. Hysiona Instural; or Iteme 23e or 28e-f ehow int, the Magical Examiner must be nailfied at		15. Decedent	Year or E	ates:	16a. Dece	dent's Usua	I Occupa	ation			16h Kir	nd of Busines	s/Industry	
3	n 72	plet	(Specify only highest Elementary/Secondary (0-12)		1.4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	<i>luring</i> mos	t of worki	ing	100. 11.	0, 5,00,00	wausy	
7	od with	Completed	8	Conage		Но	memak	er				(Own Hor	ne	
Maryland	tal Hy d oth	Be	17. Father's Name (First, Middle, L								(First, Middle.				
<u> </u>	2 should be and Mental ie marked raumatic ev	10	Clarence Thomas			10h Maili		/011			Hollens			71- 0-4	
<u>8</u>	d 2 sh th and the r		19a. Informant's Name/Relationsh Michael M. Guer		Son						Noute Number Nonsvi				
စ်	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 theme 23s or 28s-1 show filem 27 is marked other than "netural" or Iteme 23s or 28s-1 show other traumatic event, the Medical Examiner must be notilized at		20a. Method of Disposition			Place of Dispo cemetery, crei	osition (Nan	ne of			Date		cation - City o		
Ê	Page: ient o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	tro Cr				2/15	/2005	Cato	nsvil!	Le, M	aryland
Baltimore,	permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra		21. Signature Funeral Service L	icensee	-	22	Name and	d Addres	s of Facilit	у Ноп	ne of Ca	atons	ville.	Inc	
D	80 = 9		23a. Part1. Enter the disease or o	CA	12	2 1	1630	<u>Edmo</u>	<u>ndsor</u>	<u>1 Ave</u>	nue; Ca	atons	ville.	MD	21228 oximate
90,	/Medical Examiner the burial-transit	dical Examiner	shock, or heer failure. Use of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Response to Due to Due to C.	(or as a consection as a conse		ne							Onse	val Between
.O. BOX 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live I	tcome of pregn pirth 2 Feta nant at time of cown	aldeath 3	⊒Ectopic pro ⊒ Other (spo					2	3d. Date of de Month	elivery Day	Year
cords, r	quires that n signed b	ρ	Part II. Other significant condition	- 11 1	eath but not res	sulting in the u	nderlying ca	ause give	en in Part I.			obacco us Yes 2 🗆	se contribute i		se of death? 4 ∐Unknown
ပ္သ	aw re	Completed	COPID								24a. Was		24b. Were a	utopsy fin	idings available
Ĭ	The lav ate has page 2	ĕ	Histor & Bres	A Concer	. Hr.	son 1	lu	u bo	ne		autop perfo 1 Yes	rmed?	death?		on of cause of
Vital	cian: ertific ector,	Be (25. Was case efe of to medical examiner?		/	00		0			Check only o				
_	Physician: r this certific ral director,	မ	1 Yes 2 No	-		ER/Outpatier		A Othe	9r: 4 ☐ Nu		me 5 Aresid			ecify)	
0	ding h. After funer	tlon	1 ☑Natural 5 ☐ Pending		of Injury hth, Day Year)	Injury	M	8c. Injury Work	rai (? Yes 2.∐.I		28d. Describe h	iow injury	occurred		
DIVISION	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: Atter this certificate he completely filled in by the funeral director, page	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	e of Injury · At h ling, etc. (Speci	ome, farm, str fy)				-	28f. Location (S City or Tow	Street and vn, State)	Number or F	Rural Rout	e Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the examiner: On the b and man	e best of my kno basis of examina oner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a	and manner a place, and du	is stated.	ause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	10/1					number				signed (Mon		(ear)
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<u></u>	2		30. Name and address of person v	the completed cau	- 1	m 23a) (Type,	Print)	100	Costs	me	4 ND	2,2	W		
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign								- 1		
3.5	Registr			2005		W An	24 1/2 18								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#8, perFH, C853, 3/1/06 TT

Amend Item 27 per Dr., C850, 12/14/05 and

Certificate of Death

Reg. No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 30,2005 **Physician** Ellen S. Gladden November 10:50a.[™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Co. College Manor Lutherville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1920 | Months | Days | Hours | Min. | 0 9 1 2 2003 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. 217-18-0912 85 Baltimore, MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits other then "natural", or items 23a or 28e-f ehow vent, the Medical Examinar must be notified at 1 Yes 2 No Maryland N/A Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2709 Southern Ave 21214 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 □XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Eastern Stainless Steel Executive Secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if lem 27 is marked othin eny injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0scar Streett Lyda Pearce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee Hood - Cousin 1607 Ruxton Road Baltimore, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ♥ Other (Specify) Entombment Baltimore, MD Parkwood Cemetery 12-03-2005 21. Signature of Furger of Furger Cense Charles F. Miner 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc Baltimore, MD 21214 23a. Part1. Enter the disease, dishock, or heart failure. List Approximate Interval Between Onset and Death r complications that caused the death. Do not enter the moder of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 1 /Medical unto (or as a prinsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien by Physician/Medical IF FEMALE: 981 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate hes been sign page 2 should be 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury Attending 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 3 cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State BORNEL Registrar

41.7			1 - For State Registrar	State of M	aryland		artmer rtificat			ind M	_	giene Reg. Mg.	005	40298
Same.	Physici /Medi		1. Decedent's Name (First, Middle, Last) Helen Gladys	Gat	son						2. Date of De Month Dec.	Day 4	20	3. Time of Death 12:15рм
	Examir		4a. Facility Name (If not institution, give s Joseph Ritchie	street and number)			Balt	imo					county of D	eath
	Funeral Director			7. Ag	10 (In yrs. Ia 59	Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 1 – 22	th ay, Year) -46	9.	Birthplace (State or Foreign Country) MD
	Maryland a-f show	ctor	Usual Residence of Decedent 10a, State 10b, County MD		-	Town or Lo								10d. Inside City Limits 1X Yes 2 □ No
	th with the 23s or 28	al Director	10e. Street and Number 4138 Hyden Ct.				10f. Zij 21	Code 228				10g. Citize	on of What	Country?
9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic evant, ina Medical Examinal must be notified at	d by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.))- 14 S	Dinnie 18	vmerican Indian, vhite, etc. Lack
Maryland 21215-0036	od within 72 h giene. er than "natu , the Medical	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.	kind of wo	ork done d se retired,	lurina most	of workir	ng		of Busine	ess/Industry
yland	2 should be filed and Mental Hygi is marked other aumatic evant, II	To Be (17. Father's Name (First, Middle, Last) Wesley Cheesebo	ro Sr.					Mary	How				
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Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial XXCremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Bay	ace of Dispo metery, crea V1eW	cren	nato:		2-13		Dund	alk,	
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	Hunt	er	20	07 I	East	ern i	Ave.	sley C Balt	0. M	D 21	231
8760,	Physician and physician and physician and physician and the physic	al Examiner	23a. Par1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):	1					iiost,		Approximate Interval Between Onset and Death Months
.O. Box 6	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[Ectopic p					23	d. Date of Month	delivery Day Year
rds, P	Se un eg	by	Part II. Other significant conditions con	tributing to death b	out not resul	lting in the u	nderlying (ause give	on in Part I.					e to the cause of death? Probably 4 Onknown
Division of Vital Records,	The ate ha	Completed											24b. Were prior death 1 🗌 Y	
f Vit	Physician: T this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatier	nt 3 DC	Othe		-	<i>(Check only o</i> ne 5 ☐ Resid		Other (S	ipecity) HOSPICE
ion o	ding h. After fune	ertification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	M	28c. Injury Work		2	8d. Describe l		occurred	
Divis	200>	O	3 Suicide 6 Could not be determined	28e. Place of In building, el	ury - At hor c. (Specify)		eet, factor	y, office		2	8f. Location (S City or Tox		Number or	Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier Certifying Physics (Check only one)	ician: To the best ter: On the basis of and manner st	f examination	rledge, deatl on and/or in	h occurred vestigation	at the tim	e, date and pinion, deat	d place, a h occurre	nd due to the	cause(s) a date and p	nd manner lace, and c	r as stated. due to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier					c. License					-	onth, Day, Year)
1	1		90. Name and address of person o co	mpleted cause of o	leath (Item :	23а) (Тура,	Print)	12	4170)		Dece	nber	5,2005
	<i>Y</i>		E. To MD Riches 31. Date filed (Month, Day, Year)	1 Harpice	838 ar's Signatu	3 N.	Ento	w St	r 13	alti	mere,	MD	212	0)
	Sta Registi		80 mg as at	005 32. Hagisti	-	Me 1	Land!	A						

Registrar

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32 Registrar's Signature

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2005

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31. Date filed (Month, Day, Year)

DEC 14

Greene Street Baltimore NId 21201

			1 - For Stete Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H		-	giene	05	L0300
	Physici		1. Decedent's Name (First, Middle, Last) Tibor Gajary					2. Date of De Month 12		2005	3. Time of Death 04:30%m
	/Medic Examir		4a. Facility Name (If not institution, give s 11100 Bybee St.				Spring]	nty of Death Montgo	mery
	Funeral Director		5. Social Security Number 143-32-5779 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year) -1926	9. Birthp Coun Hung	place (State or Foreign htry) gary
	Maryland a-f show	tor	10a. State 10b. County MD Montgot	mery	10c. City, Town or Lo Silver					1	0d. Inside City Limits 1 ☐ Yes 2X No
	with the	Direc	10e. Street and Number	<u> </u>		10f. Zip Code	2000		10g. Citizen	of What Coun	itry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is markad other than "natural", or itams 23e or 28e-f show shy injury or other traumatic avant, the Medical Examinat must be notified at ance.	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XXV If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 223No	Specify:	Specify Yes or No to Rican, etc.)	Spe	Race - Americ Black, White, cify: Whit	etc. te
Maryland 21215-0036	I within 72 t jene. r than nate	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done o DO NOT use retired lege Prof	luring most of wo)	rking		Business/Ind	·
land 2	12 should be filed within n and Mental Hygiene. I is markad othar than raumatic avant, the Me	To Be C	17. Father's Name (First, Middle, Last) Kalman Gajary		1		18. Mother's Na	me <i>(First, Middl</i> e, La Bossat	Maiden Sum		
	t 1 and 2 shores Health and N Health and N tam 27 is ma other trauma		19a. Informant's Name/Relationship (Typ. Judith Gajary/wife			ng Address (Street a			-		Code)
Baltimore,	permit. Pages 1 a Department of He Important: If itam any injury or oth		20a. Method of Disposition 1 ☐ Burial 2√Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	sition (Name of matory or other plac ke Cremat	· 1	Date -09-2005		n - City or To	
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1	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Acute l	the death. Do not ent e. Myocardial consequence of):	er the mode of dying	g, such as cardia	c or respiratory as	rest,	.0310	Approximate Interval Between Onset and Death
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.O. Box 68	ne death certific the attending p hed for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ory Day Year
Δ.	quires that the signed by ald be detacted.		Parkinson's Diseas		it not resulting in the u	nderlying cause give	en in Part I.		obacco use co ∕es 2 □ No		ne cause of death?
Il Records,		Completed by						24a. Was autop perfo 1 □ Yes		prior to con death?	psy findings available inpletion of cause of
Vital	Physician: The this certificate har director, page	o Be	25. Was case referred to medical examiner? 1 Types 2 No	ospital:	nt 2 ER/Outpatien	ot 3 DOA	ve.	ath <i>(Check only o</i> Home 5 🔀 Resid		ther (Specific	4
ion of	ttending Phydeath. Stor: After this the funeral d	atlon: To	27. Manner of Death TMNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28c. Injury Work	at	28d. Describe h			7
Division	or A after Direction by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farm, str. . (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Nur vn. State)	mber or Rura	l Route Number,
	ha Hospital in 24 hours a he Funaral I pletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Exeminates	sician: To the best oner: On the basis of and manner sta	f my knowledge, death examination and/or in ted.	vestigation, in my or	pinion, death occu	e, and due to the curred at the time,	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
	To tha h within 2 To the F complete	Σ	29b. Signature and title of certifier			29c. License	1340		29d. Date sign	ned (Month, L 08-200	
	12		30. Name and address of person who co				0906				
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 4 2005	32. Registra	r's Signature	<i>y</i>					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** DECEMBER 10 2005 LEONARD GOLD 8:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE N/A WESLEY HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/17/1921 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 84 212-12-5417 Yrs Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6103 EASTCLIFF DRIVE 21209 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No WW II If Yes, Give Year or Dates: ARMY 1 Never Married 2 Married Maryland 21215-0036 þ Specify: WHITE 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DESIGNER KITCHEN VANITIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi h and Mental H 7 is marked otl GOLD ANNA HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an Importent: If item 27 is m any injury or other. JANICE GOLD / WIFE 6103 EASTCLIFF DRIVE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12/12/2005 OOWINGS MILLS, MD HAR SINAI CONG. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END-STAGE Physician DEMUNTIA /Medical Due to (or as a consequence of): Examiner INUBROVASCULAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗙 No 3 Probably 4 □Unknown HYPO THY ROIDISM 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 🗌 No 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 1-19425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. ROGERS AVE - BALTIMORE, MD ZIZO9 ROBERT E_ 31. Date filed (Month, Day, Year) ROBY M.D. - 2211 32. Registrar's Signature State DEC 1 4 2005 Registrar

10/2005

		1	For State Registrar	State of I	Maryland		irtment tificate			and Mer		iene	05	40302
	Physicia		1. Decedent's Name (First, Middle,	•							Date of Death Month		Year	3. Time of Death
	/Medic	al -	Margaret B.		Orl		4h Cihr	Tour or	Location o		cember		2005	4:00 A M
	Examin	er	4a. Facility Name (If not institution, Rock Springs Vi			me		est]		or Death			rford	
	Funeral Director				Age (In yrs. la		If Under Months	1 Year Days	If Under 2 Hours		Date of Birth Month, Day 18/19	l'aar)	Cou	place (State or Foreign ntry) York
	pu *	-	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryla f sho	ō	FL Saraso	ota		th Por								1 ☐ Yes 2 ☑ No
	with the 1 3a or 28e- 1 be notif	Funeral Director	10e. Street and Number 517 Tampico Dri	ve			10f. Zip	Code			10	og. Citizen o	of What Cou	intry?
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If filem 27 is marked other than "natural", or Items 23e or 28e-f show if if item 27 is marked other than "natural", or other traumatic event, it is Madical Examinations.		11. Marital Status 1 Never Married 2 Marrie	12. Was Decede Armed Force of 1 \(\superscript{Yes} \) 2 If Yes, Give	es?		Vas Deced f Yes, spec			gin? (Specify , Puerto Rica	Yes or No- in, etc.)	В	ace - Ameri lack, White	, etc.
003	nours',	d by	3 XWidowed 4 □ Divorced	Year or Date	es:									
1215-	within 72 l ene. than "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)		ient's Usua kind of wor DO NOT us ning	rk done d se retired)	luring most)	t of working		16b. Kind of Mail	Order	
Maryland 21215-0036	should be filed nd Mental Hygi marked other imatic event, il	Be	17. Father's Name (First, Middle, L Alban W. Olson	ast)	1				18. Mothe Hi1		rst, Middle, M		ame)	
Maryl	d 2 should th and Men 7 Is marke traumatic	2	19a. Informant's Name/Relationsh David Greenlund								oute Number,			
ď	Pages 1 and 2 nent of Health a ent: If item 27 Is try or other trail		20a. Method of Disposition 1 Durial 2 Commation	3 □Removal from St	ate Cé	lace of Dispo	natory or o	ther place		Date 12/14		20c. Locatio		own, State Maryland
Baltimore,	permit. Pages Department of I Importent: If ite any injury or o		* 4 □ Donalion 5 □ Other (Sp 21. Signature of Funer I Service L		met		. Name an	d Addres	s of Facilit	y Mille	er-Dip	pel Fu	ineral	Home Inc.
	40244		23a Pani. Enter the disease, or c shock, or hear failure. List of	complications that cau	sed the death h line.								yrano	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause Final disease or condition resulting in death)	a Due to (or	as a consequ		<u>Ca</u>			No. 4				
		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or	as a consequ		ites	an	1 13	lead	lig			
ر 0	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequ	ience of):								
8760,	physic physic the bu	dica		d			-						-	
.O. Box 6	death certifi e attending ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowh		h 2 ☐ Fetal it at time of de	death 3	Ectopic pr Other (sp						Date of deliv	rery Day Year
<u>α</u>	law requires that the de as been signed by the a r 2 should be detached f	by	Part II. Other significant condition	ns contributing to dea	th but not resu	ulting in the u	nderlying c	ause give	en in Part I.			acco use co		the cause of death?
Vital Records,	9 4 9	Completed	Dem	en tic	λ .	1					24a. Was an autopsy perform	v	prior to co death?	opsy findings available ompletion of cause of
tal		e Co	25. Was case referred to medical	NCERL	2/	U ul	Vy		26 Place	of Death (C	1 ☐ Yes 2 heck only one	No No	1 🗆 Yes	2 No
	d is	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 🗆 Ing	atient 2 🗆	ER/Outpatier	it 3 DC	Othe	_		5 🗆 Reside		Other (Speci	fy)
n of	<u>a</u> = <u>a</u>		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		8c. Injury Work			Describe ho	w injury occ	urred	
Division	deat deat tor:	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ation ot be 28e. Place of	Injury - At ho	me, farm, str	M eet, factory		Yes 2□I		Location (Str City or Town		mber or Rur	al Route Number,
٥	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying	g Physicien: To the b	est of my know	wledge, death					due to the ca	iuse(s) and		
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	(Check only one) 2 Medical E	exeminer: On the bas and manne		tion and/or in		, in my op		th occurred a		ate and place Od. Date sig		
	F 3 F 8		> Iduna	DIABon.	Q Mn				479				113/	
	5		30. Name and address of person v	un Roal	But	emino	Print)	J 2	-123	6 H	las A Re	D. 0	3000	M.D.
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 4	1 2005 32. R	istrar's Signa	ture	berk	,						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 60303 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month December **Physician** 6:30 AM John Joseph Hild /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manchester

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Jan. 16, 1930 Carroll Longview Nursing Home Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 213-26-5940 1**X** M 2□ F 75 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "naturel", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at tX Yes 2 □ No Md. Carroll Hampstead Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21074 3810 Normandy Dr. Unit 3D U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆E/Yes 2 □ No 1951— If Yes, Give Year or Dates: 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status tiled within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be I nent of Health and Mental I snt: If item 27 Is marked o Catherine Staab Edward F. Hild Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3810 Normandy Dr., Unit 3D, Hampstead, Md. 21074 B. Joy Hild - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cem. Dec. 16, 2005 Pikesville, Md. * 4 □Donation 5 □ Other (Specify) 21. Signature of Furieral Sirvica Licensee 22. Name and Address of Facility 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Comparison of the disease or condition of the death of the de Eckhardt Funeral Chapel, P.A. Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy 4☐Pregnant at time of death 5 Other (specify) certilicate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 700 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Atter this tuneral c 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifier 121.31.5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dec Homer 8th Home potent va & Steven 5 MAV 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 4 2005 Registrar

				State of Manuard / Dans		•	
				1- State of Maryland / Department / Department / Departmen	rtificate of Death		005 40304
	Ch Con	Physici	an	1. Decedent's Name (First, Middle, Last) Alice Marion Hart		2. Date of Death Month December	Day, 2005 8:43 a M
		/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
_				Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Havre de Grac	8 Date of Birth	Harford 9. Birthplace (State or Foreign
		Funeral Director		214-20-1320 1 M 2 F 82 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Month, Day, Y.	ear) Country)
		death with the Maryland ms 23e or 28a-f show Finust ke notified at	ctor	10a. State 10b. County 10c. City, Town or Lo	Bel Air		10d. Inside City Limits 1 □ Yes 2√□ No
no		with the	Funeral Director	10e. Street and Number 2222A Old Emmorton Road	10f. Zip Code 21015	10g	. Citizen of What Country?
W		r death	unera	11. Marital Status 12. Was Decedent Ever in U.S. 13. VARMED FORCES?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
2	9600	nours afte	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: white
8	aryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-1 show any injury or other treumatic event, the Medical Erra in at most be notified at 20ce.	Completed	(Specify only highest grade completed) (Give life. I	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) ptroller	An An	b.Kind of Business/Industry nerican Heart Assoc. (health)
,	land ;	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) James Hudgins	18. Mother's Name Marion	Norris	iden Surname)
00	Mary	nd 2 shoualth and N 27 Is mai		19a. Informant's Name/Relationship (Type, Print) Courtney Hart/son 222	ng Address <i>(Street and Number or Rura</i> 22A Old Emmorton R	al Route Number, C Load, Bel	City or Town, State, Zip Code) Air, Md. 21015
1	Baltimore,	Pages 1 a ent of He nt: If item ry or othe			natory or other place)	1.0	c. Location - City or Town, State
B	Balti	permit. Departm Importa any inju		Land Free C	2. Name and Address of Facility Schimunek Funeral		
	6	Physician pe executed / Medical Examiner Medical Examiner Line Physician and Line Physician and Line Physician	Examiner	23a Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	610 W. MacPhail Ro er the mode of dying, such as cardiac of the mode of dying.	or respiratory arrest	
	68760,	certificate be execu iding physician and ise as the burial-trai	edical	a Dehydratur			feer day
4	.O. Box 68	0 0 0	Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
1/1	rds, P	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		co use contribute to the cause of death?
3/16	I Record	The law recate has bee page 2 shock	Completed	0		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Th	of Vital	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	To Be	25. Was case referred to medical examiner? 1 Yes No 1 Anner of Death 1 Astural			e 6 ⊡Other (<i>Specify)</i> injury occurred
	Division	of or Attendir after death. I Director: Af d in by the fur	Certification;	1 Satural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, strategic and strategic an	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
		Ne Hospite n 24 hours ne Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invanily and manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred.	and due to the caus ed at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
		To the To the comp	/ Me	29b. Signature and title of pertitier	29c. License number 7 500 4		Date signed (Month, Day, Year) 12-07-2005
		N'		30. Name and address of person who completed cause of death (Item 23a) (Type, 1308 BUSINESS CENTER WAY #10	Print) 01, EDGEWOOD,		1040
		Sta Registi		31. Date filed (Month, Day, Year) DEC 1 4 2005 32 Registrar's Signature			

			1 - For State Registrer	te of Maryland		rtment of F		i Mental Hy	giene Reg. No2 ()	05 10206
rgr	Physic		1. Decedent's Name (First, Middle, Last) William Henry Hyma	ın				2. Date of De Month Decemb	eath Day	3. Time of Death 2005 12:30 A M
	/Medi Examir		4a. Facility Name (If not institution, give street a. Oak Crest Care Cente			4b. City, Town, o			4c. County	
	Funeral Director		5. Social Security Number 6. Sex 177-05-1287	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	s. B. Date of Bi (Month, D. Sept.	rth ay, Year) 19,1919	9. Birthplace (State or Foreign Country) Maryland
3altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examinar must be notified at PAGE.	To Be Completed by Funeral Director	1 Never Married 2 Married 1 Married 1 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade comp	COOM 222 SOUS Decedent Ever in U.S. ed Forces? Yes 2 No ss, Give r or Dates: WW II eled) ege (1-4or 5+) (daughter) from State	13. V It 1 1 16a. Deced (Give I life. E I NSTA) 19b. Mailing 3936 ce of Disposmetery, crem	Parkvil 101. Zip Code 2123 Vas Decedent of H Yes, specify Cubz Yes 21 No ent's Usual Occup ent's Usual Occup ent's Usual Occup ent's Ose retirect Ulation g Address (Street Norrisv sition (Name of atory or other place)	4 ispanic Origin? an, Mexican, Pu Specify: ation during most of v IEnginee 18. Mother's N Donot and Number or ille Ro	(Specify Yes or No erro Rican, etc.) working T lame (First, Middle thea Ro. Rural Route Numb ad, Jam. Date	10g. Citizen of U 14. Rac Specify 16b. Kind of B Telex Maiden Surman thlingsh per, City or Town, ettsvill 20c. Location-	10d. Inside City Limits 1 Yes 2 No What Country? I.S.A. De - American Indian, ck, White, etc. White Dusiness/Industry Dhone Company The Comp
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 23a Part1. Enter the disease, or complications		22. 9	Name and Address 705 Bela	ss of Facility S ir Rd.,	chimunek Baltimo	Funeral re, MD 2	Homes
8760,	Physician /Medical Examiner behavioral the prital-transit the prital-t	dicai Examiner	snock, or near failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a conseque	vince of):		~			Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as it	Physician/Med	in the past 12 months?	s, outcome of pregnand Live birth 2 ☐ Fetal d Pregnant at time of dea Unknown	leath 3□	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
of Vital Records, P	tw requires that s been signed b t should be deta	Completed by Pt	Part II. Other significant conditions contribution Diabetes met	g to death but not result	ing in the un	derlying cause giv	en in Part I.		Yes 2□No	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available
ital Re		Be Comp	25. Was case reterred to medical examiner?				26. Place of D	- auto	2 No	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 70
Division of \	tending Physicath. Ior: After this the funeral dia	Certification; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		R/Outpatient 8b. Time of Injury	28c. Injun Worl M 1	4 Nursing		how injury occurr	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and	To the best of my knowl the basis of examinatio manner stated.	edge, death in and/or inve	occurred at the tin estigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	To the sound of the state of th	Me	29b. Signature and title of certifier			29c. Licenso 058	641.			d (Month, Day, Year)
	Sta Registr		30. Name and address of person who completed Annual Month, Day, Year) DEC 1 4 2005	cause of death (Item 2	23a) (Type, F	Print) Bouleva	Con	Park		MD 21234

12:30.Am

HYMAN, WILLIAM

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	state of Maryland /		rtment of He		nd Men		ene 2005	40307
	Dh ini		Decedent's Name (First, Middle, Last)						Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		Tracie L.	Hubbard					_	0, 2005	0 0 1
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of	Death		4c. County of E	
			346 N. Essex Av			Essex	1611-40	41155		Balti	
	Funeral		5. Social Security Number 6. Sex 1 6. Sex	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min.	Date of Birth Month, Day,		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	33				ψu	ly 12	, 19/2	laryland
	yland		10a. State 10b. County	10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
	Mar e-f si	ctor	MD Baltimo	re Es	sex						1 ☐ Yes 2 📆No
	or 28	Director	10e. Street and Number			10f. Zip Code				g. Citizen of Wha	t Country?
	23a	rai	346 N. Essex A	ve.		21221				USA	
	tems	Funerai		Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- in, etc.)		American Indian, Vhite, etc.
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-1 show Jigal Eventral te notified at	by F	1 ★Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐Yes 2½ No	Specify:			Specify: W	hite
21215-0036	thou stura		15. Decedent's Educat		a. Deced	lent's Usual Occupa	tion		11	6b. Kind of Busin	
75	in 72	Completed	(Specify only highest grade c Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired)	uring most	of working			·
21	d within giene.	E O	Lighterially/2000s/dury (0 12)	4yrs	Т	eacher				School	
pu	be filed stal Hygid of other evant, I	Be (17. Father's Name (First, Middle, Last)	•			18. Mother	's Name (Fi	rst, Middle, M	aiden Sumame)	
yla	should be marked c metic eve	2	James Hubbard						Wimer		
Maryland			19a. Informant's Name/Relationship (Type			g Address (Street a					te, Zip Code)
e)	is 1 and 2 of Health a itam 27 is othar tree		James Hubbard J. 20a. Method of Disposition			N. Esse	X AV	Pate		Ore MD Oc. Location - City	or Town State
٥	Pages nent of I int: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Ren	oval from State cemete	ary, cren	natory or other place fFaith	" ¦ 1	2/13		Baltimo	
Baltimore,			 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	2 A			s of Facility		- 11 - 12	7.7	5 T
æ	permit. Departr Imports any inj		RTOLLY	annelly.						uneralh ore MD	IomeofEssex
			23a. Part1. Enter the disease, or emplica shock, or heart failure. List only one	ions that caused the chath. Do	not ent	er the mode of dying	, such as c	ardiac or re	spiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Possice ha							Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	0):	1001E					Offe auria
	Examiner	.	Sequentially list conditions. b	Lymphangi	lei	tailure	10595	>			yews
1	Sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duelto (olhas a consequénce	of):	1					/
V	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):			<u> </u>			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit										
687	ificate g physi as the l	edical	u								
Вох	eath certific attending p	M/u	230. was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal deat	h 3[Ectopic pregnancy				23d. Date of	,
	deat	Physician/M	in the past 12 months? 1 Pss 2 No	4 Pregnant at time of death		Other (specify)				Month	Day Year
P.O	at the de d by the etached	Phy	9 Unknowń					-	00 8/4	72.00	
	ires that signed b	by	Part II. Other significant conditions contri	buting to death but not resulting	in the u	nderlying cause give	n in Part I.	1	1 ☐ Yes	المدا	te to the cause of death? Probably 4 Unknown
0.0	w requir been si should	eted						_			
Records,	e law has b	Completed							24a. Was an autopsy perform	prior	e autopsy findings available to completion of cause of h?
al			OF Was seen informed to mudical					(5 (6)	1 ☐ Yes 2	No 1	Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 WNo	pital: 1 ☐ Inpatient 2 ☐ ER/O	utpation	t 3 DOA Othe	~		neck only one) ice 6 □Other(Caralda
of				28a. Date of Injury 28b.	Time of					v injury occurred	эреспу
ion	Attanding F r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		r es 2□N	lo			
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, str	eet, factory, office		28f.	Location (Stre		r Rural Route Number,
Ö	itel or A rs after rel Direc led in by	Cer									
	To tha Hospitel or within 24 hours after To the Funarel Dirt completely filled in I	edicai		ian: To the best of my knowledge: On the basis of examination a and manner stated.							
	To t comp	Σ	29b. Signature and title of certifier	1.4		29c. License	number	in	29	d. Date signed (M	fonth, Day, Year)
•	-		Jesui	, M.D.		סטע	618	73	13	112/0	25
	3		30. Name and address of person who com	bleted cause of death (Item 23a)	(Type,	Print)			, n		1206
	Sta	ate	SAPSAY DESA, M.D. 31. Date filed (Month, Day, Year)	32. Registrar's Signature	NIN'C	STREE!	I, DAL	TINDE	e, mary	LAND L	
	Regist		DEC 1 4 200	Dieted cause of death (Item 23a) 1830 EAST Models 32. Registrar's Signature	1						

			For State Registrar	State of	Marylan		artmen rtificat			d Mental Hy	/giene Reg. No⊋ ∩ J	(*) 3/10m	1000
ı	Physicia		1. Decedent's Name (First, Middle, La Lillian Adele Hi	•		-		·-		2. Date of D Month	/ / /	Year 2005	3: Time of Death 3
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and numb		nter			Location of De		4c. County		
	Funeral Director		5. Social Security Number 6. S			last birthday) Yrs.		1 Year Days	If Under 24 H	in. 8. Date of B	irth	9. Birthp Cour	place (State or Foreign ntry) rvland
	ס		Usual Residence of Decedent										
	farylar show	ō	10a. State 10b. County N/A			ty, Town or Lo						1	0d. Inside City Limits 12∑ Yes 2 □ No
	28a-f	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of	What Cour	ntry?
	h with 23a or 11 Le		3217 Shannon Dri	ve				212	213		U.S.	Α.	
00	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked tother than "natural", or Items 23a or 28a-f show armatic event, the Medical Examinar must be rediffied at	by Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedor Armed Force 1 Yes 2 If Yes, Give	es? ☑ No	1	Was Dece If Yes, spe		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		ce - Americ ck, White,	etc.
-000	hours tural',	q pa	3XXVidowed 4 ☐ Divorced 15. Decedent's E	Year or Date	es: 	16a. Dece	dent's Usu	al Occupa	ation		16b. Kind of B		
	within 72 ene. than "na ha Medic	Completed	(Specify only highest gra	College (1-4	or 5+)	(Give life. House	kind of wo DO NOT u	rk done d se retired	during most of v)	working	Own Hor		
land	itd be filed fental Hyg rked other ic event, l	To Be C	17. Father's Name (First, Middle, Last Joseph Kosojet)		,				Name (First, Middl a Janda	e, Maiden Suman	ne)	
>	コモトキ		19a. Informant's Name/Relationship (Robert Hirt/Son	Туре, Print)			-			Rural Route Num Ottinghar			
ore,	ges 1 a it of He if item or othe	ř	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		ato (Place of Disponentery, crea	matory or a	other plac		Date / 1 / 1 / 0 5	20c. Location		
банттог	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		50		-		em. 12,				Maryland Home Inc.
מ	88 = 8		Jan 1	may						Baltimon		land	
	Physician /Medical Examiner		23a. Part. Enter the disease, or comshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or	Pohe	quence of):	er the mod	ae or ayın	g, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
ļ		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated greater.	b. Due to (or	as a consec	quence of):		er -	me	Dian			
8/60,	sate be executed hysician and the burial-transit	ai Examiner	that initiated events resulting in death) Last	c. Due to (or	as a miseo	quence of):	ه ا	J V	Deme	Diseas	<u> </u>		
280	ficate physis the	edicai	•	d	200/1		rno		100			8	
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ⊡Feta ntattime of d	al death 3	∃Ectopic p ∃ Other <i>(s</i>					ite of delive onth	ery Day Year
7.	res that thigned by	þ	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	ınderlying	cause give	en in Part I.		tobacco use con	tribute to th	ne cause of death?
Division of Vital Records,	law require as been si 2 should b	Completed								24a. Wa	san 24b.	Were auto	psy findings available
Ì		Com								per 1 □ Yes		death?	2 🗆 No
ZI S	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		3550		Oth	-	Death (Check only		- 10	
5	ding Physi h. After this c	7: To	1 ☐ Yes 2 ☐ Ho 27. Manner of Death	28a Date of	Injury	ER/Outpatier 28b. Time o		28c. Injun Worl	4 Lanursing	g Home 5 Res	how injury occur		y)
on	ath. or: Afte	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Day Year)	Injury	М		K? Yes 2 □No				
DIVIS	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	200. Flace 0	f Injury - At h g, etc. (Speci	iome, farm, sti fy)	reet, factor	y, office			(Street and Numb own, State)	ber or Rura	l Route Number,
	Hospi 24 hour Funer stely fill	Medical		nysician: To the b miner: On the bas and manne	is of examin								
	ro the	Me	29b. Signature and title of certifier	•			1		e number		29d. Date signe	d (Month,	Day, Year)
	,- > F 0		> palta			ND		D 3	31464		12(1	3(0	2
	1		30. Name and address of person who	_				lot (ST fin	F 3N8	RAITIN	1011	MU 21201
	Str	ate	31. Date filed (Month, Day, Year)	SHMIM 32. P	gistrar's Sign		MIN	r V	21 1100	W 200	13,10((1)	COICE	110 2120)
	Regist		DEC 1 4 2	005		H A	and!	D.					

Amend item#20b, perFH G850, 12/15/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pandal If Under 1 Year Timese I Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 □ F Months Hours Yrs 223-34-5569 Director 3-10-30 75 Va. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itame 23a or 28a-f show the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director Baltimore Randallstown Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9828 Tolworth Circle 21133 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Ves 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No ρ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Beth Steel traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be filment of Health and Mental Hant: if Item 27 is marked oth jury or other traumatic even Julian Jones Iona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9828 Tolworth Circle, Randallstown, Md. Margaret L. Jones Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Th 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: if sny injury or once. Garrison Forest Vet. 12-17-05 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** : ratury /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Laure Due ty (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this natifications have been expected as the funeral Director. attending physicien and for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 🗓 No 1 2 Inpatient 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 32. Registrar's signatur 31. Date filed (Month, DEC 9ay, Year State Registrar

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	lental Hy	giene Reg. No.	05	40310
П	Physici	an	Decedent's Name (First, Midd								2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	al	James Lee 3 4a. Facility Name (If not institution		harl		4b. City, To	um or	l continu		December		005	12:03 p M
	Examir	ier	1544 N. Srticker		Delj				more	or Death		46. 00	ounty of Deat NA	n
	Funeral		5. Social Security Number	6. Sex	Age (In yrs.	last birthday)	If Under 1	Year	If Under:		8. Date of Birt	h · Yaari	9. Birti	hplace (State or Foreign untry)
	Director		248-58-3674	1 X M 2□F	65	Yrs.	Months D	Days	Hours	Min.	8. Date of Birt. (Month, Day 08-05-19	40°	South	n Carolina
	and		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Maryi -f sho	ţō	MD	NA.			Baltimor	e						1 XYes 2 No
	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or fams 23a or 28a-1 show sht, the Medisel Exert wer must be rodified at	Funeral Director	10e. Street and Number				10f. Zip Co	ode				10g. Citizer	n of What Co	untry?
	ath will	alD	1544 N. Stricker S	treet			21	.217					USA	
	ar dea	nuel	11. Marital Status	12. Was Deced	ces?	S. 13.	Was Deceden	t of His Cuban	panic Orig , Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 🔀 Divorced	M Van Chi)		1□Yes 2🛭	No	Specify:			Sp	ecify:	ack
21215-0036	2 hou atura	ted	15. Deceder	nt's Education		16a. Dece	dent's Usual C	Occupat	tion			16b. Kind	of Business/l	
215	thin 7 e. an "n	npte	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-	4or 5+)	(Give life.	kind of work of DO NOT use		ıring most	of worki	ng			
7	ed wi ygien nar th t, the	Completed	6				Laborer						Constru	ecton
and	ntal H ed oth	Be	17. Father's Name (First, Middle, Fred L. Jones	(Last)						r's Name line	(First, Middle,	Maiden Su	mame)	
Maryland	should ind Men s marke umatic	T _o	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address /S	treet ar			I Route Numbe	r City or To	num State 7	in Cadal
<u>≅</u>	and 2 sealth ar n 27 ls		Lauree Simpson/ Au			1					ltimore,M			ip code)
re,	of Heal		20a. Method of Disposition			lace of Dispo	sition (Name natory or othe	of			ate		ion - City or 1	Town, State
<u><u>E</u></u>	Pages ment of I ant: If its ury or o		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		tate	Zion Ce	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2-15-	05 I.	ansdow	ne, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show amount injury or other traumatic avent, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	>		Name and A			,	638 N. Gi	.lmor S	t. Balt	imore, MD21217
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca t only one cause on ea	used the death ch line.	n. Do not ent	er the mode o	f dying,	such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between
H	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a +	HRYA	14EA	L	CA	NC	Er				9nset and Death Months
	/Medical Examiner		resulting in death)	Due to (c	r as a consequ	uence of):								
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (a	r as a consequ	uence of):								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	S .										
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (c	r as a consequ	ience of):								
8760	ate hy the	dical		d										
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ord	equire en siç ould b										1 X Y	es 2□N	o 3 🗆 Pro	bably 4 Unknown
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<u>س</u>		Con									perform	ned? No	death?	2□ No
<u> </u>	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:							Check onl on			
ō	Phys rthis ral dii	7	1 Yes 2 No 27. Manner of Death	1 □ In 28a. Date of		ER/Outpation 28b. Time of		Other:	4 1401		ne 5 Reside			ify)
on	nding th. : Afte e fune	ation	1 Natural 5 Pendir 2 Accident investi	ng (Month	Day Year)	Injury	М	Injury a Work?	s 2∐N		ou. occoribe ric	, wangary oo	No. 11 Oct.	
Division of	Atternation of the py the	Certification	3 Suicide 6 Could 4 Homicide determ	nined 286. Place C	of Injury - At hor g, etc. (Specify	me, farm, str	eet, factory, of	fice		2			umber or Run	al Route Number,
ā	tal or rs afte al Dir	Cert	- Trombas	Dallan	g, etc. (Specify	,					City or Towr	i, Siate)		
	To the Hospital or Attending Physicien: whith 24 hours after death. To the Funaral Director: After this certification in the funeral director, completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifyir Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examinati	wledge, death ion and/or inv	occurred at the estigation, in	ne time my opir	, date and nion, death	l place, a n occurre	nd due to the ca d at the time, da	ause(s) and ate and plac	manner as s ce, and due t	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifie	er (cense r					gned (Month,	
•			> Illin	L D	~	\circ	7	12	90	71		12.	12.	2005
	5		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	<u> </u>			V 2	/ -		2005- NONE 2120
	9		RANANDA 31. Date filed (Month, Day, Year)	KNZI	jiştrar's Signat	10	111.	tU	1/2	151	# 500	5 8/	AU71	NOVE 2120
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Amend Item 2	State of Marylar Ob per fh G850	nd / Departme 0 12 Striff &	ent of Hea a te ®f De	alth and I eath	-	giene Reg. No. 0 0 5	40311
	Physic /Medi		1. Decedent's Name (First, Middle, Las	7 Kni	ght			2. Date of Dei Month DECEMB	Day Year	3. Time of Death
	Examir - Funeral		4a. Facility Name (If not institution, give SAIM AGNES HI 5. Social Security Number 6. Se	street and number) OSPITAL x 7. Age (In yrs.	4b. C B last birthday) If Un		MORE Under 24 Hrs.	8. Date of Birt	4c. County of De	A irtholace (State or Foreign
1	Director		2 18 - 36 - 7208 10 Usual Residence of Decedent 10a. State 10b. County	JM 2 ØF (2)	Yrs. Month	ns Days F	Hours Min.	Month, Da	y, Year)	Country) Caryland 10d. Inside City Limits
	he Maryi 28a-f eho	ector	md N	A	Bal	tim	ne			1 Yes 2 □ No
	ath with the 23s or 3	Funeral Director	10e. Street and Number 144 Pal	ormo Au	re	Zip Code	229		10g. Citizen of What C	country?
5-0036	irei', or item	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, s	.N.	inic Origin? (Si Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc. Black
21215-(is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "nature!, or items 23a or 28a-f show other traumatic event, the Medical Exerties must be ricitiled at	Completed	15. Decedent's Edi (Specify only highest grad	College (1-4or 5+)	life. DO NO	work done durin	ng most of work		16b. Kind of Business	s/industry
Maryland	should be filed with ind Mental Hygiene marked other the umatic event, Ins.	To Be (17. Father's Name (First, Middle, Last)	Allen			Aln	na.	Maiden Sumame) BRWN	
e, Mar	1 and 2 sho Health and em 27 ie m		19a. Informant's Name/Relationship (7) Bridgette Knigh 20a. Method of Disposition	+ - Daughter	137 Pa	lorm	o Ave.	Back		1229
Baltimore	Page nent c ant: if ury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	13	Place of Disposition (/	~ 0 .	12/1	6 0 5	Batter	
Bal	permit. Departr Imports any inji		21. Signature of Fyreral Service L	Yhad	Gar	L P.M	arch	Rener of	Home Ba	eto, md, 21229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caulsed the deat ne cause on each line. a	CANC	-	uch as cardiac	or respiratory ari	est,	Approximate Interval Between Onset and Death MOMHS
8760, <	hysicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque. Due to (or as a conseque)						
P.O. Box 68	The law requires that the death certificate be executed its has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3 Ectopic				23d. Date of de Month	olivery Day Year
rds, P	w requires that been signed t should be deta	ρ	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the underlying	g cause given in	Part I.	23e. Did to	bacco use contribute to	o the cause of death?
		Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
⋚	Physician: this certificaral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatient 2 □	ER/Outpatient 3	Oth		h Check only on		
n of	ding Phy h. After thii funeral c		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			ence 6 Other (Spe	icity)
Division	or Atten ter deat irector: I by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	M ome, farm, street, fact	1 ☐ Yes		28f. Location (St City or Town	reet and Number or Ri 1. State)	ural Route Number,
	Hospit 24 hour Funere stely fills	edical Ce	29a. Certifier (Check only one) 10 Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurre	ed at the time, d	ate and place, n, death occur	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	s stated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainler stated.	2	9c. License nur	mber	2	9d. Date signed (Mont	h, Day, Year)
			Xomsa Khin	Hivenion, 1	MD	P13	1602	D	ECEMBER	2,11,2005
	5		30. Name and address of person who co	ENICZ, 900 (n 23a) (Type, Print)	ENUE	BALI	IMORE	MARYLY	WD 21229
	Sta Registr	111.00	31. Date filed (Month, Day, Year) DFC 1 / 2005	32. Registrar's Signa	Angelis !		1		V = 65	

			1- For Amend Items 25tate of Maryland Certification Certification	traent of Health and Me ficate of Death	•	•
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
. 6	/Medic	al	Robert W. Keil	4b. City, Town, or Location of Death	December	r 1, 2005 2:30 AM ^M
1	Examin	er	Homewood at Crumland Farms	Frederick		Frederick
100 m	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day,	Birthplace (State or Foreign
	Director		577-03-6726 1 ★ 2 F 95 Yrs. M			n 1910 Washington DC
	inyland	_	10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits
	Be-fe	Director	MD Frederick Frederic			1 ☐ Yes 2√ No
	with ti	Dir	10e. Street and Number 7407 Willow Road #342	10f. Zip Code 21702	10	g. Citizen of What Country? USA
	death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	as Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or liems 23s or 28e-f ehow event, the Medical Examirer must be multified at	by Fui		res, specify Cuban, Mexican, Puerto H] Yes 2∰ No <i>Specify:</i>	iican, etc.)	Black, White, etc. Specify: white
8	Phour	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Deceden	nt's Usual Occupation	1	6b. Kind of Business/Industry
215	hin 72 9. an "na Medil	Completed	(Specify only highest grade completed) (Give kin life. DO	nd of work done during most of working NOT use retired)	g	efense Intelligence
7	ed wil ygien yer th ner th	Соп	12 3 photo m	nap interpreter		gency
Maryland 21215-0036	ibe fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name Mabel Ade	, ,	· ·
Ž	shoute nd Me mark imatie	To		Address (Street and Number or Rural		
	and 2 valth a n 27 le er trau		Helen Keil/spouse 7407 W	/illow Road #342 F	rederic	k, MD 21702
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturel", or Items 23s or 28e-f ehow amy injury or other traumatic event, the Medical Examinet must be nutified at ODGe.		1 Burial 2 Cremation 3 Hemoval from State	ion (Name of Da tory or other place)	ate 2	Oc. Location - City or Town, State
altin	nit. Pa vartmer ortant injury			Name and Address of Facility		
ä	Depa Impo any i		Renald S. Mide Director Sta Bal	ite Anatomy Board timore, MD 21201	655 W.	Baltimore Street
Į,			23a. Part Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or	respiratory arre	st, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a	11/5/4 /014	1/om	1 Years
	Examiner		Sequentially list conditions, b.			17
	pe pe pe pe pe pe pe pe pe pe pe pe pe p	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
΄,	te be executed ysician and te burial-transit	Exan	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
3760,		cal	d			
x 68	entifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	death certifica e attending ph d for use as th	ician	23b. Was decedent pregnant in the past 12 months? 1	ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	ires that the death signed by the atte d be detached for	Phys	9 Unknown			
Ś	The law requires that the ate has been signed by the bage 2 should be detache	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		acco use contribute to the cause of death?
COL	w requir s been si should	iete	Atom Thulleton 3/hy	n thy can	24a. Was an	24b. Were autopsy findings available
Vital Record	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Som			autopsy perform 1 Tes	prior to completion of cause of ed? death? ☐ Yes 2 ☐ No
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
of	Attending Physicien: or death. ector: After this certific by the funeral director,	: To				nce 6 Other (Specify) w injury occurred
ion	uttending death. ctor: Afte	atior	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	e Hospital or Attend 24 hours after death Funerel Director: etely filled in by the t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	Bf. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
0	pital c					
	To the Hospital or within 24 hours after To the Funerel Dirtompletely filled in I	edical	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death o (Check only one) and manner started.	stigation, in my opinion, death occurred	d at the time, dat	te and place, and due to the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifer	29c. License number	29	d. Date signed (Month, Day, Year)
)			1 Mayor Cung	M() D16428		12/1/05
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri			
	Sta	ite	Casper E. Cline, 300 West Nineth Str. 31. Date filed (Month, Day, Year) 5	eet, Frederick, M	D 21755	
	Registi					

DHMH 17 Rev 1/2001

J.O. L.

20.1 19/1/05

			1 - For State Registrar	State of Ma	aryland		artmen				ental Hy	/gier	0000		10313
ı	Physici /Medic		1. Decedent's Name (First, Middle, La Helen Betty Kaspe								2. Date of De Month 12	eath	ay Ye	ear	3. Time of Death 01:00P ^M
	Examin		4a. Facility Name (If not institution, giv 3225 Ludham Drive				4b. City,		Location		12	4	Sc. County of D	Death	01:001
	Funeral Director		Social Security Number 6. 9	Sex 7. Ag 1 □ M 2 □ F	e (In yrs. la	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 11–28–	rth ay, Yea	9.		
	aryland show	-	Usual Residence of Decedent 10a. State 10b. County			, Town or Lo									d. Inside City Limits 1 Yes 2 □ No
	ith the M or 28e-f	Director	MD Montgome	ery	Silv	er Spi	10f. Zip					_	Citizen of Wha	t Countr	
	death w	Funeral	3225 Ludham Drive	12. Was Decedent	Ever in U.S	S. 13.	209 Was Deced		spanic Ori	gin? (Spe	cify Yes or No	US o-	14. Race - A		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If frem 27 is marked other then "neturel; or Items 23a or 28e-f show any injury or other treumetic event, the Wedical Examinations in the Collect. Other 2006.	by	1 Never Married 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	40	1	1 ☐ Yes 2	. 4	Specify:		-lican, etc.)		Black, V Specify: W		
213-0030	thin 72 h ie. ien "nett	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		i+)	(Give life. l	dent's Usua kind of wor DO NOT us	k done di e retired)	uring mos	t of workin	ng	16b.	Kind of Busine	ess/Indu	stry
and 21	e filed wi al Hygien I other th vent, I'm	Be Con	17. Father's Name (First, Middle, Last)		Off	fice M		18. Mothe		(First, Middle		chitect	ure	
ıryıa	should b nd Ment marked imetic e	Tof	Louis Gold 19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a			erman	er. City	or Town, Stat	e. Zin C	Code)
ğ.	1 and 2. Health are 27 is sm 27 is ther treu		Jane Hawes/daught	er	20h PI		Ludha	m Dr		ilve:		ng,	MD 209	06	
baltimore	Pages ment of h ent: If its ury or o		1 ☐ Burial 2 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specia		CB	sapeak	natory or of ce Cre	her place emato	ry 1	2-13-	-2005	Be1	Location - City .tsvill	e, N	1D
סמ	Depart Import any in		21. Signature of Funeral Service Lices	1/	1358	Ra Ra	Name and	a Address	s of Facilit	y Silv Crema	er Spi	ing	MD 2	0910) Gist Ave.
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	plications that caused one cause on each lir a. Cardio I Due to (or as b. Anemia Due to (or as	Pu1mo a consequ	Do not entendenten	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,		A In	Approximate nterval Between Onset and Death
,00/00,	The law requires that the death certificate be executed attentions been signed by the attending physician and page 2 should be detached for use as the burial-transit.	edical Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c. Monoclor Due to (or as	nal G	ammopa ence of):	thy		-						
.O. DOX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date of Month		ay Year
r (spins)	quires that an signed build be det	þ	Part II. Dther significant conditions of	contributing to death bu	ut not resul	lting in the ur	nderlying ca	use giver	n in Part I.				_	e to the	cause of death?
		Completed									24a. Was autor perfo		prior death	to comp	y findings available pletion of cause of
V 11 d	rnysicien: in this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	005	ER/Outpatien	2000	Othor	~		(Check only o	one)			
	tending Physicien: Jeath. tor: After this certific the funeral director,	atlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		lc. Injury	4 🗀 1401		8d. Describe		6 Other (S	pecify)	
בואלו	to the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not b 4 Homicide determined		iry - At hor :. (Specify)	ne, farm, stre	eet, factory,	office		28	Bf. Location (: City or Tox	Street a wn, Stai	and Number or te)	Rural R	loute Number,
:	io the hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier Check only one) Certifying Ph	nysicien: To the best of niner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred a restigation,	t the time in my opi	o, date and nion, deat	d place, ar th occurre	nd due to the d at the time,	cause(s date ar	s) and manner nd place, and c	as state lue to th	e cause(s)
	with To To COIT	Σ	29b. Signature and title of certifie	8	110		29c.	License	number	45	-	29d. Da	ate signed (Mo	onth, Da	y, Year)
	10		30. Name and address of person who Jack Epstein 1081					ngto	n, M	0 208	95				
	Sta	_	31. Date filed (Month, Day, Year)	2. Registra			AC .	-							

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		Please I	State of Maryl				-		
		1 - For State Registrar	State of Mary		rtificate of			2005 g. No.	40314
		1. Decedent's Name (First, Middle, Last)				2. Date of Death	h	3. Time of Death
Physi /Me	ician dical	TROCHYM K	ARPUS				DEC.	12,2005	5:30 a ^M
Exan						r Location of Death		4c. County of Death	
		GENESIS ELDERCAL 5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year	RKVILLE If Under 24 Hrs.	8. Date of Birth	BALTIMO	nplace (State or Foreign
Funera		215-30-3271 Usual Residence of Decedent	THA OF F	01 Yrs.	Months Days	Hours Min.	FEB. 12	2,1904 U	KRAINE
land ow		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
Man B-feh	ţ	MD. BALTI	MORE	ES	SEX				1 ☐ Yes 2X No
ith the	2	10e. Street and Number			10f. Zip Code		10	ng. Citizen of What Cor	
s 23e	Funeral Director	1532 DOOLITTLE	ROAD 12. Was Decedent Ever	in 11 6 12		1221	agaity Vac or No-	U.S.A.	
ter de	901	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 27 No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	o, etc.
hours at tural', or	Ž	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: WH	ITE
within 72 hours after death with the Maryland ene. If then "natural" or Items 23e or 28e-f ehow he Medical Examination is to motified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of world)	king	16b. Kind of Business/l	ndustry
a filed within at Hygiene. I other then "	2	Elementary/Secondary (0-12)	College (1-4or 5+)	1	MACHINI:		1	AMERICAN	CAN CO.
filed w Hygien other th	2				I II I OII I I I I		e (First, Middle, A		
IGING lid ba fill fental H rkad oth	9	1	US			VASII	LYNA L	EBYD	
Tarylan 2 should ba 1 and Mental 10 markad reumetic ev		19a. Informant's Name/Relationship (T	vpe, Print)		•			City or Town, State, 2	ïp Code)
2 5 5 5 F		WILLIAM KARPUS/				TREET, W			21162
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀	Terrioval from State		osition (Name of matory or other pla	1	No.	20c. Location - City or	
ILIN iit. Pa artmer ortant injury		4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens							ROOK, N.J.
Dall permit. Departri importa eny inju	ouce) faction	va tare	1 F	ILLY & 901 EAS	ZEILER TERN AVI	INC. FUI INUE, BA	NERAL HOM	E D. 21231
400		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.						Approximate Interval Between
Physicia	an	Immediate Cause (Final disease or condition	Coro	man	/	- Dise			Onset and Death
/Medic Examine	_	resulting in death)	Due to (or as a co	nsequence 1):					
LXamin		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):					-
uted d ansit		cause. Enter Underlying Cause (Disease or injury that initiated events							
6U, be axecuted ician and burial-transit	2		Due to (or as a co	nsequence of):	, , , , , , , , , , , , , , , , , , , ,				
ate be a hysiciar the buris	0	(d						
BOX 68/60, sath certificate be axecuted attending physician and for use as the burial-transit		IF FEMALE:	23c. If ves, outcome of pr	egnancy				23d. Date of deli	ivon
death cer death cer deattendir deattendir	0	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
the dy the ached	1	1 Yes 2 No 9 Unknown	9□ Unknown						
Hecords, P.O. The law requires that the de te has been signed by the a age 2 should be detached 1	3	Part II. Other significant conditions co	ntributing to death but no	t resulting in the i	underlying cause gr	ven in Part I.		pacco use contribute to	4
ecords, taw requires t as been signe							1 □ Y€	es 2 No 3 Pro	obably 4 Niknown
Hecc e taw r has be ge 2 sh	1						24a. Was a autops perform	y prior to d	topsy findings available completion of cause of
	,						1 ☐ Yes	No 1 ☐ Yes	20 No
Y VITAL K ysician: The is certificate hi director, page	c	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	ent 3C DOA Ott	non l	th (Check only on	e) ence 6 ⊡Other <i>(Spe</i> d	rify)
			28a. Date of Injury (Month, Day Ye	28b. Time	-	rv át		ow injury occurred	
ath. Presenting later		1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		ary injury		Yes 2 □ No			
Division or Attending Phywithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		27. Manner of Peath 1	28e. Place of Injury - building, etc. (S	At home, farm, si pecify)	treet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
Div To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	3		ysician: To the best of m	v knowledge, dea	th occurred at the ti	me, date and place	, and due to the ca	ause(s) and manner as	stated.
e Hos 24 hc e Fun		29a. Certifier Check only 2 Medical Examone)	iner: On the basis of exa and manner stated.	mination and/or i	nvestigation, in my	opinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
To th within To th		29b. Signature and title of certifier			29c. Licen	se number		9d. Date signed (Montl	
		1/2/			D	59423	7	Reemby 1	3 2005
10		30. Name and address of person who	ompleted cause of death	1 11	100	0 R 160.	= # - /-	3-01	3 2005 MD 21239
	Stat	31. Date filed (Month, Day, Year)	32. Registrer's	Signature	Capital My	of business	3. 203 C	MITTIMONE,	MD 61637
	jistra		2005	· K	Louis)				
					100				

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ORIGINAL

		Please [*] Unpend item#23a,2 1 - ^{Sor} 1 - Registrar			ertificate of		Reg.		40315
Physicia	an	1. Decedent's Name (First, Middle, Las			, , , , -		2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, give	4 LEXA	NDER	LONG	r Location of Death	DEC. 9,	2005 4c. County of Death	0830 A M
Examin	er	GOOD SAMARITAN HO				RE CITY		4.5	IA
Funeral Director		5. Social Security Number 6. Se 17-90-3113 Usual Residence of Decedent	x 7. Ag	e (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birth	pplace (State or Foreign Intry)
yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Ba-1 e	ctor	MARYLAND N	1A		BALTI	HORE	CITY		1 X Yes 2 □ No
C Z IZ I 3-UU30 filed within 72 hours after death with the Maryland Hygiene. sther than "natural; or Iteme 23a or 28e-1 ehow snt, tra Medical Examinat must be notified at	by Funeral Director	4000 Corse	A115 A	のナキュ	10f. Zip Code	1121	/ 10g.	Citizen of What Co	untry?
death w	nera	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of H	lispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	
d within 72 hours after giene. giene. er than "natural", or ite	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 □ If Yes, Give	No	1 ☐ Yes 2 🕱 No	an, Mexican, Puerto F Specify:	ncan, etc.)	Black, White	, etc.
hours tural',		3 Widowed 4 Divorced 15. Decedent's Edi	Year or Dates:	16a De	cedent's Usual Occup	· · · · · · · · · · · · · · · · · · ·	16h	. Kind of Business/l	LACK
Madic	Completed	(Specify only highest grad	de completed) College (1-4or 5	(Gi	ive kind of work done DO NOT use retired	during most of working	ng 100	. Raid of Dusinessy	and stry
Hygiene. other than ent, the M	Con	12 HGRADE		MA	TERIAL	HAND	LER E	BERRY.	PLASTICS
e d ala	Be	17. Father's Name (First, Middle, Last) JOSEPH		101		18. Mother's Name	(First, Middle, Maid	len Surnamel)	2
should ind Men marke umatic	J.	19a. Informant's Name/Relationship (T	ype, Print)	19b. Ma	ailing Address (Street	and Number or Rural	Route Number, Cit	ty or Town, State, Z	ip Code)
w = w		LAKETA LONG	3 (DAUGH	TER) 23	25 Ho	LINS ST	. APT. 405	BALTO. M	10.2/223
m O		20a. Method of Disposition 1. Surial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis	sposition (Name of rematory or other place	D:	ate 20d	Location - City or 1	own, State
Parit P		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		ARBUTU	S CEMETO 22. Name and Addre	ERY! 12-1	6-05/	ALTIMORE	MARYLAND
permit. Departr Importe any inju		21. Signature of American Service Literature	(. 4), Os	linn	JOSEPY	H. BRO	MIE B	FUNERA. ALTO, MÓ	-7/2/7
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused	the death. Do not one.	enter the mode of dyin	g, such as cardiac or	respiratory arrest,	121 1 10	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a Sarcoidos						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
and transit	amlner	Cause (Disease or injury that initiated events resulting in death) Last	c						
be extician a	E	resulting in death) Last	Due to (or as	a consequence of):					
ficate g phys	edlc		d					i	
ires that the death certificate be executed signed by the attending physician and to detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delik Month	very Day Year
	'Ph	Part II. Other significant conditions co	entributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
s that ned by	- T						1 □ Yes	2□No 3□Pro	bably 4 □Unknown
equiles triat								24h Were aut	opsy findings available ompletion of cause of
s law requires that t has been signed by e 2 should be detai							24a. Was an autopsy	prior to c	
i: The law requires that is icate has been signed by r, page 2 should be detai	Completed						24a. Was an autopsy performed	prior to co	2 🗆 No
rsicien: The law requires that t s certificate has been signed by lirector, page 2 should be deta	Be Completed	25. Was case referred to medical examiner?	Hospital: 1 □ Innatis	unt 2% FB/Outnet	ient 3 DOA Oth	26. Place of Death	Yes 2 Check only one	? prior to co death? No 1 Yes	2 □ No
ig Prysicient: The law requires mart ter this certificate has been signed by neral director, page 2 should be deta	To Be Completed	examiner? TYP Yes 2 No 27. Magner of Death	1 U Inpatre		IONE 3 DOA	er: 4 Nursing Hom	Yes 2 Check only one	Prior to content? No 1 ✓ Yes 6 ☐ Other (Spec	2 □ No
sending Frigatoless: The taw requires tract or Affact this certificate has been signed by the funeral director, page 2 should be detailed.	To Be Completed	examiner? ty Yes 2 No 27. Magner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of Inju	ry y Yea <i>r)</i> 28b. Time y Yea <i>r)</i> Injur	of 28c Injury	er: 4 Nursing Hom	check only one	Prior to content? No 1 ✓ Yes 6 ☐ Other (Spec	2 □ No
if the death. Director: After this certificate has been signed by in by the funeral director, page 2 should be detail in by the funeral director.	To Be Completed	examiner? YE Yes 2 No 27. Magner of Death 1 Anatural 5 Pending	28a. Date of Inju	y Year) 28b. Time Injur	of 28c Injury	er: 4 Nursing Hom y at 2 k? Yes 2 No	Check only one) 18 5 Residence 8d. Describe how in	Prior to c death? No 1 Yes 6 Other (Specially your occurred	2 □ No
 Hospitel or Attending Physician: The law requires that the hours after death. Funeral Director: After this certificate has been signed by etely filled in by the funeral director, page 2 should be detained. 	Certification; To Be Completed	examiner? No Yes 2 No 27. Magner of Death 1 A Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physics	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et	ry Year) 28b. Time Injurury - At home, farm, c. (Specify) of my knowledge, defeamination and/or	of 28c Injury	er: 4 Nursing Hom y at k? Yes 2 No	Describe how in the cause and due to the cause	Prior to c death? No 1 Yes 6 Other (Specially occurred and Number or Rui ate)	2 □ No fy) ral Route Number,
anding Physicien: The law requiath. or: Afler this certificate has been he funeral director, page 2 should	To Be Completed	examiner? 1x Yes 2 No 27. Manner of Death 1 Anatural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Cretifying Phy (Check only 2 Medical Exam	28a. Date of Inju (Month, Da 28e. Place of Inju building, et	ry Year) 28b. Time Injurury - At home, farm, c. (Specify) of my knowledge, defeamination and/or	of y American Street, factory, office street, factory, office street, factory, office at the time investigation, in my of the street street.	er: 4 Nursing Hom y at k? Yes 2 No 2 ne, date and place, a pinion, death occurre e number	Check only one) 18 Seribe how in the cause of at the time, date a 29d. I	Prior to clean? I and Number or Rui and Number or Rui and place, and due Date signed (Month)	2 No Ify) al Route Number, stated, to the cause(s) Day, Year)
To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to	Certification; To Be Completed	examiner? No Yes 2 No 27. Magner of Death 1 Anstural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Inju (Month, Da) 28e. Place of Inju building, et vsician: To the best iner: On the basis of and manner sta	28b. Time Injury 28b. At home, farm, c. (Specify)	of y 28c. Injury Wor 1 Street, factory, office eath occurred at the tin investigation, in my o	er: 4 Nursing Hom y at k? Yes 2 No 2 ne, date and place, a pinion, death occurre e number . M.E.	Check only one) 18 Seribe how in the City or Town, St. at the time, date at the tim	prior to death? cheath? 1 Yes 6 Other (Specially occurred and Number or Rulate) (s) and manner as and place, and due Date signed (Month) DEC. 10,	2 No No No No No No No No No No
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			1 - For State Registrar	State of M	laryland	d / Depa	artmen	t of H	lealth a		lental Hyg	giene	ns.	1.0016
			Registrar 1. Decedent's Name (First, Middle, Last	1		Cel	rtificate	e or L	Jeath		2. Date of Dea	Reg. No:	U J	3. Time of Death
	Physicia	an			ther	ino		Γ 57	ons		Month 12	Day 12	05	10:50a ^M
	/Medio Examin		Sarah 4a. Facility Name (If not institution, give			1116	4b. City,		Location of	of Death	12		ty of Death	
	LXamiii	CI	Keswick Nursing					tim						
-	Funeral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)	9. Birth	place (State or Foreign intry)
	Director		212-16-6129]M 210F	95	Yrs.				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	02 2	6 10		М́D
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl -f sho ied s	ρ	MD NA		Balt	timor	e							XXYes 2 □ No
	r 28e	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cou	untry?
	h with	Funerai Director	940 Brooks Lane					21	217			ī	J.S.A	• <i>P</i>
	ems serm	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13. \	Was Deced	lent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Amer ack, White	ican Indian,
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes XX If Yes, Give	No		1 □ Yes		Specify:		,	Spec	ifv.	
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f show the Mcdical Examiner must be notified at	ed b	3 XWidowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:		16a. Deced	dent's Heur	d Occupa	ation			16b. Kind of		Black
15	in 72 n "ne	piet	(Specify only highest grad	le completed)	5)	(Give	kind of wor DO NOT us	rk done d	during mosi ()	t of worki	ng	166. Killa of	Dusinessyn	lidustry
212	d with giene. ir the	Completed	12th grade	Coilege (1-4or na	5+)	Ве	auti	cia	n			Beau	ty Sł	nop
b	al Hygin other	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Suma	ame)	
yla	Ment Ment arked	To I	Lloyd T. Peaker						Jul	ia I	Oorsey			
Maryland	2 short and lam		19a. Informant's Name/Relationship (T				_				I Route Numbe	-		
	1 and 1ealth sm 27 ther t		Harry Peaker-Sc 20a. Method of Disposition	on	20h Pla						altimo:	20c. Location		1217
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other then "netural", or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 ☐ Cremation 3 ☐ I		7	ace of Dispo							•	
量	artme artme ortant injury		 4 □ Donation 5 □ Other (Specify, 21.		Arbi		Memo . Name an				12/16/	205 A1	couti	is, Ma
Ba	Depa Impo any ir		No BO		U	M	arch	F/	H We	st	Balt	imoro	ма	21215
			23a. Part1. Enter the disease, or comp	lications that cause	d the death.								Mu	Approximate
	Prrysician		shock, or heart failure. List only o	ne cause on each	ine.	-56	921	6	Im	en	ten			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	s a consequ	ence of):	1	3						1
	Examiner		Sequentially list conditions	b										2.90
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury	Due to (or as	s a consequ	ence of):								
	and and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):								rae .
8760,	ate be executed hysician and the burial-transit	cai E		, ,	,	,								
9	ificate g phy: as the			u										
Box	death certifics e attending pl id for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth			Ectopic pro	nanan av				23d. D	ate of deliv	rery
B		Physician/Med	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (sp					N	lonth	Day Year
P.O.	at the 1 by th etach	Phy	9 □ Unknown											
	The law requires that the deate has been signed by the a sage 2 should be detached for	by	Part II. Other significant conditions co	Hery	1 -	iting in the ui	naeriying ca	ause give	an in Part I.		238. Dia to	1-		the cause of death? bably 4 □Unknown
Orc	w requir been si should	eted	000	7			1-0	C PC				/ \		
Records,	has l	Completed	Saulun								24a. Was a autops perfor	sy med?	. Were auto prior to co death?	opsy findings available empletion of cause of
Vital	ician: The certificate ha ector, page	e Co	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·						/0 ::	1 ☐ Yes	2.No	1 🗆 Yes	2 No
5	Phyaician: rthis certific ral director,	O B	examiner?	Hospital: 1 ☐ Inpati	ient 2 🗆 E	R/Outpatien	t 3 🗆 DO	A Othe			_(Check only or ne 5 □ Resid		ther (Speci	6.1
of	iding Phyaician: th. : After this certifica i funeral director, p	n: T	27. Manner of Death	28a. Date of Inju		28b. Time of Injury		Bc. Injury Work			28d. Describe h			'97
jo	Attending r death. •ctor: After	atio	1 Natural 5 Pending 2 Accident investigation	(INOTAL), De	ay 16a1)	injury	М		Yes 2 □ 1	No				
Division	r Atte ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At hor tc. (Specily)	ne, farm, str	eet, factory	, office		2	28f. Location (S. City or Tow	treet and Nun n, State)	ber or Run	al Route Number,
Ω	urs af urs af sraf D													
	Hosi 24 ho Fund stely f	edicai	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Examone)	ner: On the basis of and manner si	of examination	vledge, death on and/or inv	occurred a restigation,	at the tim in my op	ie, date and pinion, deat	d place, a th occurre	and due to the cod at the time, d	ause(s) and n late and place	nanner as s , and due t	stated. o the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	1	-0				number			9d. Date sign		
).	> = 0		My Horth	my th	Key,	, wo	1)2	500	2	1.	Dec	ent	10v13 2000
	n		30. Name and address of person who c	omp sted cause of	death Item	23a) (Type,	Print)	11	1	0	CI	0 1	111	12,20g
	2		W lt. 12.1.	dy 6-6	me	67	011	V . C	la	ele,	J/1 1	Jalt	, File	1508
	Sta Registr		31. Date filed (Month, Day, Year) DFC 1 4 2	32. G gist	rar's Signati	G. A	serte)	•						
			Sept.	A -4 CO CO		58								

Tayshone Love 05-8210 AKG

Baltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Love 2005 7:09 P Tayshone December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore n/a Saint Agnes Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M &F 217-90-3573 Director 28 Md Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10c City Town or Location 10d Inside City Limits 10a, State 10b. Count or 28a-f ehow f health and Mental Hygiene. Item 27 is marked other then "natural", or Itema 23a or 28a-f ehov other traumatic event, it a Modical Examinar must be notified at 1. Yes 2 No Completed by Funeral Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 S. Fulton Avenue 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12th grade Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny ligury or other traumatic event ang. injury or other traumatic event Be Benjamin Love, Jr. Barbara Herbert ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Fisher Mother 3810 Midheight Road, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-9-05 King Mem. Park Randallstown, Md. 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 adip Wome March F.H. East 1101 E. North Ave. Approximate Interval Between Onset and Death 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Asthma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[\] No certificete Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 XYes 2 ☐ No 1 Inpatient 2 XER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Ptace of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

or Attending Physician: The law requires that the death certificete be executed Box 68760. P.O. Division of Vital Records. within 24 hours after To the Funeral Dire

Director:

State Registrar

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

w

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

> O.C.M.E. December 6, 2005

30. Name and address of person who completed dayse of death (Item 23a) (Type, Print) THE ODORE MILL

111 Penn Street, Baltimore, Maryland

32. Segistrar's Signature

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylan	-	artment of				iene	5	403	18
			Decedent's Name (First, Midd	e, Last)					2	. Date of Deat Month	h Day	Year	3. Time of	
	Physicia /Medic		Anna Mild:	red McCaus	land				I	ecembe		005	615	AM
	Examin		4a. Facility Name (If not institution	n, give street and nui	mber)		4b. City, Town,	or Location	of Death		4c. Count	y of Death		
			Eldercare		7 4 //	for a belief of a ch	If Under 1 Yea	Arbut		Date of Birth			1timor	
	Funeral Director		5. Social Security Number 219-03-4584	6. Sex 1 M 2 F	7. Age (<i>In yr</i> s. 86	Yrs.	Months Day		Adim	Date of Birth (Month, Day, ec. 18	Year) 1918	9. Birth	place (State on try)	
		ŀ	Usual Residence of Decedent						1 12	. 10	, 1710	Tia	тутапс	
	nyland how		10a. State 10b. County		10c. Cit	ty, Town or Lo							10d. Inside C	•
	e Ma Sa-f s	Director		ltimore			Arbuti							2 X No
	dith th	Dire	10e. Street and Number 5108 She11	noumno Doo	נ		10f. Zip Code	21227		1	0g. Citizen of			
	s 23g	eral	11. Marital Status		edent Ever in U	S 13	Was Decedent of		igin? (Specif	ty Yes or No-		ed St	ican Indian,	
36	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show disal Examinat must be mulffied at	by Funeral	1 Never Married 2 Ma 3 Widowed 4 XX ivorce	ried Armed Fo	rces? 2⊠No ve		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2점 N			can, etc.)	Bla	ack, White, fy: Whi	etc.	
21215-0036	"nature	Completed		nt's Education est grade completed)		16a. Dece	dent's Usual Occ	upation	st of working		16b. Kind of E	Business/Ir	ndustry	
21	S E	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work don DO NOT use reti	red)	g					
121	71 -		12 17. Father's Name (First, Middle	(act)		Nurse	s Aid	19 Moth	or's Name /	First, Middle, M	Health		2	
anc	be d d o	Be C	John Weisinger	Lasij							naiddir Obrina	,,,,		
Maryland	d 2 should th and Mer 7 Is marks traumatic	ပ္	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Stre		ha Gri eror <i>Rum</i> al F		City or Town	, State, Zi	p Code)	
	and 2 sealth ar n 27 is	1	Kathy McCausla	nd/Daughte	er in La	w 7915	Briard	len Dr	ive Ur	it IF	1kride	e MD	21075	
re,		1	20a. Method of Disposition 1 Burial 2 Cremation				osition (Name of matory or other p		Dat	8	20c. Location	- City or T	own, State	
imo	Page nent c		1 □ Burial 2 N Cremation 4 □ Donation 5 □ Other (Wes	Crema	del tory		12-07-	-2005 O	denton	, Mar	yland	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.	1	21. Si matur lo Funera Servic	LID-IISOF	TILA	1011	2. Name and Add							
	70 E 2 9		CON NAM	Charle	V/W		328 Su1					, MD		
П			23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause on e	each line.		/ ^	1					Approximation Interval Bet Onset and	tween Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cen	ebrour	450 Ul	AR Acc	iden	ブー	TROK	<u>e</u>		45 di	445
ı	Examiner		,	Conf.	or as a consec	quence of):	an. IN	SUFFIC	deur				10 xc	i dos
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):			/	8			, , , ,	1110
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1 Gen	epalis	zed A	THERE	sele	Pasis	5			20,0	AR8
o,	exectan and and and and and and and and and a		resulting in death) Last	Due to	(or as a consec	quence of):								
8760,	ate be hysic the bu	llcal		d				_						
x 68	entific ding p	/Mec	IF FEMALE:	23c If yes ou	tcome of pregna	ancv					224 D	ate of deliv		
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	birth 2 Feta	al death 3	Ectopic pregnar Other (specify)	псу				lonth	*	Year
Ö	t the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn			,							
0	The law requires that the ate has been signed by th page 2 should be detache	by Pi	Part II. Other significant condit	ions contributing to d	leath but not res	sulting in the u	nderlying cause	given in Part	l	23e. Did tol	acco use cor	ntribute to 1	the cause of	death?
rds	w require been sig should b	edt	CORONARY HE	PART DISC	erse,	Rec	reen	- 47	RIA	1 □ Ye	s 2 🗆 No	3 Pro	babiy 4 🗍	Unknown
Records,	ne law requ i has been ge 2 shouit	plet	FIBRILLATION	Empli	ysem.	A				24a. Was a autops	V	. Were autr	opsy findings ompletion of o	available ause of
H	The late happage	Completed		/						perform	ned?	death? 1 ☐ Yes	2 No	
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	al Hospital:) the new		Check only on		A	SCICTO	d
of	S S	T0	1 Yes 2 No	1 1 1	Inpatient 2	ER/Outpatie	IL SEL DOA		-	d. Describe ho		ther (Speci	W) LIVI	26
	Jing After fune	tlon	1 ☑ Natural 5 ☐ Pend	ing (Mor	of Injury oth, Day Year)	Injury	V	lork? □Yes 2.□		g. 2000.20	,,			
Division	l or Attending after death. Diractor: After in by the fune	flca	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h	nome, farm, st	reet, factory, offic	:0	28	f. Location (St	reet and Num	ber or Rur	al Route Nun	nber,
Dİ	5 5 th 6	Certification;	4 Homicide	build	ling, etc. (Speci	ny)				City or Town	i, State)			
	To the Hospital or Attentwithin 24 hours after death To tha Funeral Diractor: completely filled in by the	Medical (ing Physician: To th f Examiner: On the t and man										s)
	To the within To the comp	X	29b. Signature and title of certif			. 0/		nse number			9d. Date sign			
•			runga)ATT	CHOING	, ruys	ICIAN)	1)16	200	2 4	eceml	DER (w, 200	<i></i>
1	2/2		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type	Print) 410EN	Claric	~ / n	1	The of the	ills.		,,,8
	1		31. Date filed (Month, Day, Yea	// //	Pogistrar's Sign	ature	TIVEN	LAUCE	CNA	1014	IONSUL	ue n	KU Z	1220
	Sta Regist	ate rar	nec 1	4 2005	S. S. S. S. S. S. S. S. S. S. S. S. S. S	K A	ically B							
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ORIGINAL

			For State Registrar	State of Ma	aryland / I	•	rtment of H			Reg No.	05	031	9
	Physicia	n	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of	f Death
	/Medic			RRIS					Novemb		2005	1:0	00 a ^m
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, or		eath	4c. C	County of Death		
			FUTURE CARE-HOL 5. Social Security Number 6. S		e (In yrs. last bi	rthdav)	BALTIM If Under 1 Year		rs. 8. Date of Bir	th	N/A 9. Birthu	olace (State o	or Foreign
	Funeral Director	Ì	1	□ M 2\\\	93	Yrs.	Months Days	Hours M	lin. (Month, Da	ıy, Year)	Coui	ntry) [†] H CARC	-
			220-05-7724 Usual Residence of Decedent						7100 1				
	how		10a. State 10b. County		10c. City, Tow	m or Lo	cation					10d. Inside C	
	e Ma	cto	MARYLAND N/A		BAL	TIMO	ORE						2 □ No
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	ath w	rai	2700 N CHARLES	· · · · · · · · · · · · · · · · · · ·	D 1- 11 C	12.1		218	(Cacaity Van ar N		U.S.A. 4. Race - Ameri	can Indian	
	er de Items	Funerai	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		13.	Yas Decedent of H Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	,.	Black, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married	If Yes, Give Year or Dates:	10		☐ Yes XXNo	Specify:		5	Specify: BLA	CK	
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show alcal Examiner must be notified at	pet	15. Decedent's E	ducation	16a	. Deced	lent's Usual Occup	ation		16b. Kin	d of Business/in	dustry	
215	within 72 ene. than "na	pie	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	life.	kind of work done of OO NOT use retired	during most or (()	working				
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yla	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ite M	၉	unknown						unknown				
Maryland			19a. Informant's Name/Relationship (,		Rural Route Numb			Code)	
	1 and Health em 27 ther tr		Ronald Sisnglet	ary/Grands			Walker sition (Name of	Rd., Fr	ceeland Mo		1053 ation - City or T	own, State	
Jor	0 0		1 X Burial 2 ☐ Cremation 3 [cemete	ery, crer	natory or other plac		. 12 05				70
Baltimore,			' 4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice		MT CA		CEMETER		2-13-05		DALK, M		
Ba	permit. Departr Imports any inju		13/11/14 (LLIAM C L206 W NC		COMMUNITY	FUNE	RAL HOM	E P.A.	
	THE REAL PROPERTY.		23 Part1. Enter the disease, or can shock, or heart failure. List only	plications that caused	the death. Do					rrest,		Approxima	ite tween
	Physician		mmediate Cause (Final	one cause on each is	"(ere)	5/4	l IZ	Ca. Oon	- clina	0		Interval Be Onset and	Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence	of):	U-4	,	1 000	we		00.40	
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V	ecute and I-trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence	of):							- A
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68760,	licate be executed physician and s the burial-transit	edical Examiner		_ d									
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ă	death cert e attending ad for use a	Icla	in the past 12 menths? 1 ☐ Yes 2 ☑ No	4□Pregnant a	2 Fetal deat t time of death]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day	Year
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	w requires that s been signed to should be deta	by P	Part II. Other significant conditions	contributing to death b	out not resulting	in the u	nderlying cause giv	en in Part I.			se contribute to		
ord	requires t		<i>d</i>	our -	7000	17)		- 1	Yes 2]No 3∏Pro	bably 4	Hinknown
Records,	G 2 C	Completed		A-true	l'1	to	b		_ 24a. Was		24b. Were autoprior to condeath?	opsy findings empletion of	cause of
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u	ding After fune	tion	1 Natural 5 Pending	(Month, Da	y Year)	Injury	Wo	k? Yes 2∐No					
Division	Attending r death. ector: After	fica	3 Suicide 6 Could not	28e. Place of In	jury - At home,	farm, st	reet, factory, office		28f. Location	(Street and	Number or Rui	al Route Nur	mber,
Ω	al or / after I Dire d in b	Certification:	4 Homicide	building, e	tc."(Specify)				City or 10	iwn, State)			
	To the Hospital or Attsnowithin 24 hours after death To the Funeral Director: completely filled in by the	ai C	29a. Certifier 1 Lertifying P	hysician: To the best	of my knowledg	ge, deat	h occurred at the ti	ne, date and p	lace, and due to the	cause(s)	and manner as	stated.	(s)
	the Ho hin 24 the Fu	ledical	one)	and manner st		VUIII			ACCUSED AT THE THE				(-/
	with To t	Σ	29b. Signature and title of certifier	//_	ma		29c. Licens	se number	6	29d, Date	signed (Month	(Jay, rear)	
			1 4	VII 1	ייו			1116	7	12	1141	-)	
	2		30. Name and address of person who	Acord piloted cause of	death (Item 23a) (Type,	38 60	Cene T	nee 1	2	Suit	-300	
		ate	31. Date filed (Month, Day, Year)	32. Føgist	rar's Signatur	, ,	barte				3	1000	
	Regist		DEC 14	2005	was sis	19							

November 391

morris, Rose

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2:00 P M 10, 2005 December Ethel L. McMahon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bond Forest Assisted Living Finksburg Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F Yrs. 84 220-05-4075 Director July 16, 1921 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthen "natural", or iteme 23a or 28e-f ehow I'm Medical Examinat must be notified at Maryland Carroll Sykesville 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 7418 Village Road Apt. 17 United States Pages 1 and 2 should be filled within 72 hours after death inent of Health and Mental Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ie marked Albert A. Torney, Sr. Amelia E. Waibek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 ie
any injury or other treu 1410 Hull Street, Baltimore, Maryland 21230 John P. McMahon 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 12/14/2005 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatur of Funeral Service Liornsee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final 04 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burlal-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ď ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 2 / No 1 Yes 1 🗌 Yes : After this certifical funeral director, I Be 25. Was case referred to medical 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Death Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Crossroad Drs Sente 340 Owings Mills Md. 21117 lavio

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month Pay, Year)

32. Redistrar's Signature

ORIGINAL

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MOORE 5:30AM 13 2005 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Center Examiner BALTIMORE BAYN GU MEDICAL HOPKINS 7. Age (In yrs. last birthday Funeral Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 KF Months Days Hours Min Director 217-32-8715 VA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exaciner count be notified at 1 Yes 2 □ No Director BALTIMORE TURNER STATION MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21222 215 WALNUT AVENUE USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of fled within 72 hours after de thygiene.

other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHILDCARE DAY CARE PROVIDER t and 2 should be filed with Health and Mental Hygien tem 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOLENA BANNER WILLIAM I. MABRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 Is sny injury or other trai once. ALICE PAYNE/DAUGHTER 6 LOCKETT CT., ESSEX, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State Balto, MD 4 Donation 5 Other (Specify) 12-14-05 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NOTONIC disease or condition resulting in death) /Medical Que to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe ? res No certificete 25. Was case referred to medical hize J. 1 Yes 1 🗌 Yes 2 No : After this certifice a funeral director, Hospital or Attending Physician: Be 26. Place of Death | Check onty one examiner' Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes ≯ No 9 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending within 24 hours after death. To the Funeral Director: A М 1 Tes 2 No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Curoffar Medical (Check only one) 29b. Signature and title of certifier 29c. License number Kes-060 Asympan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEIGAN Yours HORAIUS BAYNEW ASTMONT 31. Date filed (Month, Day, Year) 32. Registear's Signature

DHMH 17 Rev 1/2001

Registrar

DEC 1 4 2005

			1 - For State Registrar	State of Ma	ryland / Dep Ce	ertificate of L	ealth and M Death	Mental Hygi	ene 0 0 5	40322
4.	Physici /Medi		Decedent's Name (First, Middle, Last) GEORGIA		MC	ORE		2. Date of Death Month 12	Day Ye 9 200!	
100	Examir		4a. Facility Name (If not institution, give	nue Apt. 9		Balt	Location of Death		4c. County of D	
Ž.	Funeral Director		5. Social Security Number 6. Sec 238-34-2477 Usual Residence of Decedent	7. Age	(In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) 5–28–	rear)	Birthplace (State or Foreign Country) N.C.
	e Maryland 3a-1 show	ctor	Md. 10b. County		10c. City, Town or Balt	imore				10d. Inside City Limits XXYes 2 □ No
	3s or 21	i Director	10e. Street and Number 2501 Violet Avenu	e Ant. 9	10-N	10f. Zip Code 21215		109	g. Citizen of What USA	Country?
900	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-1 show ha Macical Exeminer must be notified at	by Funeral		12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, Inite, etc. Black
21215-0036	be filed within 72 hours ital Hygiene. d other then "natural; event, the Medical Exe	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+	(Giv	edent's Usual Occupa e kind of work done d DO NOT use retired) Nursing A	uring most of worki	ing 16	Sb. Kind of Busine	,
Maryland 2		To Be Co	12th grade 17. Father's Name (First, Middle, Last) Mack		Hairston			e (First, Middle, Ma	Hospit aiden Sumame)	.dl
	27 I		19a. Informant's Name/Relationship (Ty Elaine Hairston		-in-law	ling Address (Street a	ntral Ave	enue, Bal		
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Greenm	ount Cem.	12-1		oc. Location - City Baltimor	
Bal	Departr Departr Imports any inju		21. Signature Funeral Service License	le		March F.H	I. East	1101 E	imore, N E. North	Md. 21202 Ave.
	Physician /Medical Examiner		23a Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		consequence of):	later the mode of dying	Canac	or respiratory arres		Approximate Interval Between Poset and Death
8760,	cate be executed obysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
ords, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions con	tabuting to death but	not resulting in the	underlying cause give	n in Part I.	23e. Did toba	V _	to the cause of death? Probably 4 □Unknown
al Reco		e Completed	25. Was case referred to medical					1	prior t	
Division of Vital Records,	ysic is ce direc	To B	examiner?	ospital: 1 Inpatient 28a. Date of Injury (Month, Day		of 28c. Injury Work	4 Nursing Hor	1	ce 6 Other (S	pecify)
Divis	P Birdin	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, si (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	ne Hospitel	edicai	29a. Certifier (Check only one)	ician: To the best of er: On the basis of e and manner state	xamination and/or if	th occurred at the time nvestigation, in my opi	e, date and place, a nion, death occurre	and due to the caused at the time, date	se(s) and manner and place, and d	as stated. lue to the cause(s)
,	To the Ho within 24 I To the Fu completely	Ň	2. b. Sign fur and title of certifie	MM	·D,	29c. License		29d	Date signed (Mo	7 - 2005
+	7 /		LN LRIGO D.	mpleted called of deep	1-240	Print) W. DE	IVEDEU	LE AVE	BALTI	9-2005 MONE MD 21213
	Sta Registr		31. Date filed (Month, Ody, Year) DEC 1 4 200	32 Registrar	s Signature			,	,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 12:30d Joseph Vernon Marshall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 6. Sex Funeral 1□M 2□F X Yrs. Director 1916 216-01-2096 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Harford Bel Air Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 U.S.A. 403 Cedar Spring Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo white δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry automotive and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 years quality control (General Motors) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h Elva Westerfield Edward A. Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny injury or other trains Marie V. Marshall/wife 403 Cedar Spring Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/16/05 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Superico 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final ur sion Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Examine burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given, in Part I. 23e. Did tobacco use contribute to the cause of death? þ 10C0 1 🗌 Yes 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA 28a. D. te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 ☐ Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be To the Hospins...
within 24 hours after de
To the Funeral Direct 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lesopeone Dr. Bel Al yah 34Q4Q 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 4 2005 Registrar

			1 - For State Registrar		State of M		/ Depa		t of H	ealth a	and M	lental Hy		1000	1. 1	10321
	Physic /Medi		1. Decedent's Name JOSEPH		st) MENTO							2. Date of De		1 2ď		3. Time of Death 4:00 a _M
	Exami			not institution, giv	e street and number, UE				Town, or	Location o	of Death			County of C		
To.	Funeral Director		5. Social Security N 21740357	4	Sex 7. Ag	ge (In yrs. las 63	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da 12/18	1941	9. M	Birthplac Country IARYI	ce (State or Foreign LAND
	yland now		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation							10d	I. Inside City Limits
	Ba-1 el	ector	MD	BALTIMO	RE	ROSI	EDALE									1 □ Yes 2 No
	3a or 2	i Dir	10e. Street and Nur 1227 DAI	TON AVEN	UE			10f. Zip	Code 1237					zen of What JSA	Country	'?
9600	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "natural", or items 23a or 28a-1 show event, the Misdical Exeminar must be notified at	d by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	ed 🄏 Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe), Puerto	ecify Yes or No Rican, etc.)		14. Race - A Black, W Specify: W	/hite, etc	·
Maryland 21215-0036	C 20	Completed	(Special Elementary/Second 12	15. Decedent's E- ify only highest gra ndary (0-12)	ducation ade completed) College (1-4or			lent's Usua kind of wo DO NOT us NGINE	rk done d se retired,	ition <i>luring m</i> osi)	t of worki	ng		nd of Busine	ess/Indus	stry
yland	S should be filed within and Mental Hygiene.	To Be C	17. Father's Name (MENTO						LOUI	SA	(First, Middle	ONNO			
Mar	를 5 를 다	5	19a. Informant's Na ALICE L.		Type, Print) WIFE			g Address DALT				l Route Numb LTIMORI				nde)
Baltimore,	00		20a. Method of Disp 1 Burial 24 4 Donation	osition Cremation 3 5 5 Other (Specif	Removal from State	cem	e of Dispo etery, cren RO CR	natory or o	ther place			/2005		cation - City		
Balt	permit. Pag Department Important: i eny injury o		21. Signature of Fu	S rvice Licer	9		22	. Name an	d Address	s of Facility	VENU	CH/ROSI E BAL		E FUNE RE, MD		
Service Service	Physician // Medical Examiner It is prize transit The prize transi	Icai Examiner	shock, or hear Immediate Cause (idsease or condition resulting in death) Sequentially list conif any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) L	iditions, mediate tying	b. Due to (or as Due to (or as Due to (or as	a consequen	nce of):							ER	Int Or	oproximate terval Batween nset and Death YEARS
P.O. Box 68	the death certific by the attending p ached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	Ectopic pre Other (spe		-			2	3d. Date of o	delivery Day	y Year
rds, P	w requires that been signed b should be det	by	Part II. Other signifi	cant conditions c	ontributing to death b	ut not resultir	ng in the un	derlying ca	iuse giver	n in Part I.						ause of death?
ď	The tte h	Completed										24a. Was autop perfor	rmed?	prior t death	o comple	findings available etion of cause of
VII.	Phyeician: Th r this certificate ral director, pag	To Be	25. Was case referrence examiner? 1 Yes 2 1		Hospital:	nt 2 ER	Outpations	207.00	Other			(Check only o				
Division of Vital	Jing Afte fune		27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inju (Month, Da		b. Time of Injury		Bc. Injury	4 🗀 1401	2	ne 5 Resid 8d. Describe h			pecify)	
Divis	To the Hospitei or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 🗍 Suicide 4 🗍 Homicide	6 Could not be determined	28e. Place of Injubulding, etc	ury - At home c. (Specify)	, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	Street and m, State)	Number or	Rural Ro	oute Number,
	To the Hospitei or A within 24 hours after To the Funerat Dire completely filled in b	Medical	one)	∠ Medical Exam	ysician: To the best of tiner: On the basis of and manner sta	examination	dge, death and/or inv	estigation,	in my opi	nion, death	place, a	d at the time, o	date and p	place, and d	ue to the	cause(s)
	Twit		29b. Signature) and t	7 .	relam	(T. A)			License	_				signed (Mo	-	
(30. Name and addre		completed cause of di			Print)	110	deli	shi	2 2006	d, T	12-2 Baltur	nose	MD-2123
	Sta Registra	te	31. Date filed (Month	Day, Year)	32. Registra	r'e Cianature										

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of	Maryland	-	artment of H		nd Menta	ıl Hygie Reg.	200)5 !	03	26
	Physici	an	1. Decedent's Name (First, Midd.	le, Last)					2. Dat	e of Death	Day	Year	3. Time of	Death
4	/Medic	al	JOSEPH		MEISE					EMBER	12, 2	2005	5:30	A. M.
7	Examin	er	4a. Facility Name (If not institution FOREST HILL HI		-	ER	4b. City, Town, or	EST HI				ty of Death IARFORI	1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last		If Under 1 Year	If Under 24		e of Birth onth, Day, Ye			ice (State o	or Foreign
ш	Director		215-05-4604	1 X]M 2□ F	88	Yrs.	Months Days	Hours		28/19		Mary		
	and *	1	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, T	own or Lo	ocation						d. Inside C	ity Limits
	ours after death with the Marylan raf', or Itams 23a or 28a-1 show Examitier must be notified at	ō		ford									1 🗌 Yes	
	r 28a	Director	MD Har:	tora	ral.	lstor	10f. Zip Code			10g.	Citizen of	f What Count	y?	
	th wit	aD	2700 Laurel 1	Brook Road			21047			1	U.S.A	١_		
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Originan, Mexican,	n? (Specify Ye Puerto Rican,		14. Ra	ace - America ack, White, e		
36	s afte		1 ☐ Never Married 2 ☐ Mar 3 🕅 Widowed 4 ☐ Divorced	. If ₹è s, Giv	0		1 ☐ Yes 2 🗓 No	Specify:		,	Spec			
5-0036		Completed by		Year or Da	MM TI	I6a. Dece	dent's Usual Occupa	ation		16	. Kind of I	Whi Business/Indi		
215	C 2	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during most o	of working				,	
CA	filed withi Hygiene. other then	Com	11			Sh	eet Metal				Sheet	Metal	_Indu	ıstry
Maryland	chould be filed and Mental Hygia marked othar matic evant, II	Be	17. Father's Name (First, Middle,					18. Mother's	s Name (First,	Middle, Mai	den Suma	ime)		4
7	should be and Mental marked o	ပ္	Lawrence B. I			10b Maili	ng Addense (Ctrost		bara Cl			- 6	3	
Ma	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Helen E. Mart				ng Address (Street							
ē,	es 1 ar of Hea of Hear of Item		20a. Method of Disposition		20b. Plac	8 OI DISDO	U Laurel esition (Name of matory or other place		Boad -	200	SEON, Location	- City or Tov	n, State	21047
E			1 💢 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (5		state	-	Memorial		2/15/20	OG Bo	7 74-	n Mare	.land	
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Funeral Service	Licensee		2	2. Name and Addres	ss of Facility	E. F.	Lassal	n Fu	neral	Home.	P.A.
_	20 E 2 9		CA. O	assaln		1	1750 Bela	air Roa	ad - Ki	ngsvi	lle,			
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on e	aused the death. I ach line.	Do not en	er the mode of dyin	g, such as ca	ardiac or respir	atory arrest,			Approximat Interval Bet Onset and i	ween
į.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ ae	uline	10	Then	~					onsot and	Doutii
	Examiner			Diffe to (or as a consequen	nce of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	nce of):								-
V	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	S .										
, 0	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequen	nce of):								
8760	the ch	dlcal		d										
9 X	attending properties for use as	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregnancy	v					224 0	lata of dalivos		
Вох	teath atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live bi	irth 2 Fetal de ant at time of deat	ath 3	Ectopic pregnancy Other (specify)					ate of deliver fonth		Year
0	at the de by the tached	hysi	9 Unknown	9□ Unkno)WN									
S, P.	es tha gned be det	by P	Part II. Other significant conditi	ions contributing to de	ath but not resulting	ng in the u	nderlying cause give	en in Part I.	23	e. Did tobac	co use cor	ntribute to the	cause of o	feath?
ord	w require been si should I	ted	-afeb						-	1 ☐ Yes	2 🗆 No	3 Proba	bly 4 🗀 t	Jnknown
of Vital Records,	e law r has be je 2 sh	Completed	recent for	ulue					24	a. Was an autopsy		. Were autop	sy findings pletion of c	available ause of
E E									10	performed Yes 2		death? 1 ☐ Yes 2	000	
Vita Vita		Be	25. Was case referred to medical examiner?	Hospital:			Othic	05 .	f Death (Chec				-	
		.: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date o	of Injury 28	VOutpatier 3b. Time o	IL SLIDUA	4 Nurs	ing Home 5 (28d. De	Residence scribe how i				-
<u>o</u>	Attending ir death. ector: After by the fune	atloi	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Monti tigation	h, Day Year)	Injury		k? Yes 2.∐No	0					
Divislon	or Attence after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 289. Place	of Injury - At home	e, farm, sti	eet, factory, office		28f. Loc Cit	ation (Stree	t and Num	nber or Rural	Route Num	ber,
	pital or Atten burs after deat leral Director: filled in by the													
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier Certifyi (Check only 2 Medical	ing Physician: To the I Examiner: On the ba and mann	asis of examination	dge, deat and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, death	place, and due occurred at th	to the caus e time, date	e(s) and m and place	nanner as sta , and due to t	ted. he cause(s	;)
	vithin 24 hore to the Hose To the Furce completely	Me	29b. Signature and title of certific				29c. License	e number		29d.	Date sign	ed (Month, D	ay, Year)	
T.			David	250			D 3	229-	7	D	elem	her	12.2	200
	641		30. Name and address of person					ביד אדי	MD	,			,	J
	Sta	te	DR. DAVID DUNN 31. Date filed (Month, Day, Year	r) 32. Re	MACPHA	0		EL AIR	., 1111.	21014				
	Registi		DEC 1 4 2005 Resur & South											

			. For	State of Marylan	d / Depa	artment of	Health an	d Mental Hy	giene	long 1 m
_			For Stata Registrar		Cei	tificate of	Death		Rag. No. U	5 40327
	Physici /Medio	3	V Decedent's Name (First, Middle, Lash	I LUCII	L ,		11	2. Date of De	/PAY XO	Meler 3. Time of Death M
	Examin	er	4a, Facility Name of not institution, give	street and number)	M	46. City, Town,	or Location of E	Death	4c. County	
	Funeral Director	6	MATURE 1	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. State of 8th Min. Month Da		Birthplace (State or Foreign Country) NEW YORK
	r 28s-f show	J.C	Usual Residence of Decedent 10a. State 10b. County N/A	10c. Cir	y, Town or Lo	cation ·	110			10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	158.28.3	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	Α
	death with		617 N. CLINTON				2120		USA	
980	or its	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of f Yes, specify Cul		? (Specify Yes or No Puerto Rican, etc.)		ce - American Indian, ck, White, etc. ^{fy:} BLACK
2-0	72 hours "naturel",	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occu	during most of	f working		lusiness/Industry
21215-0036	s 1 and 2 should be filed within 7. Health and Mental Hygiene. If marked other then "n other traumatic event, tra Medi	Completed	Elementary/Secondary (0-12) 8TH	College (1-4or 5+)		00 NOT use retir GE BUII	*		C	ONSTRUCTION
pu	should be filed within of Mental Hygiene. marked other then matic event, the M	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		•
Maryland	should be and Mental Is merked o	ို	ROGER MDNEILL 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Stree		ARLOTTE or Rural Route Numb		
	1 and 2 s Health ar tem 27 ls		CLARA JOHNSON(F				TON S	T. BALTI		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crea	sition (Name of natory or other pla		Date		- City or Town, State
altin	mit. Paramento portant		4 □ Donation 5 □ Other (Specify) 21 Snature of Funeral Service Licens	ee // TR	22	. Name and Addr	ess of Facility			TIMORE, MD.
ä	Depar Depar Impor eny ir		Demadine	1. Deruge	~ 1	412 E.	PREST	UGGS FUN ON STREE	T BALT	IMORE, MD. 212
10	Physician /Medical		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	S	er the mode of dy	ing, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death One Man Th
	Examiner			Due to (or as a consequence)		G				one month
1/	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):	,			-	
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09289	6 × 6	dical	(d						
P.O. Box (Attending Physician: The law requires that the death certifica death. cleath. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3[Ectopic pregnand Other (specify)	су			ate of delivery onth Day Year
	quires that the signed by ald be detact	by	Part II. Dther significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.		tobacco use con Yes 2 □ No	tribute to the cause of death?
Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was auto perfo 1 Yes	psy prmed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vita	nysician: The la iis certificate ha director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	,		han	Death (Check only		
of	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	€R/Outpatier 28b. Time o	JU DON	4 140131	ng Home 5 Resi	dence 6 Oth how injury occur	
Division of	ttending I death. ctor: After y the funer.	catio	1º⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury	M 1[Yes 2 No			
Divi	after d	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, str y)	eet, factory, office		28f. Location (City or To		ber or Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edicai C	29a. Certifier (Check only one)	sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	n occurred at the vestigation, in my	ime, date and p opinion, death	place, and due to the occurred at the time,	cause(s) and madate and place,	anner as stated. and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	Attending Ph	ysicie	29c. Licer	se number		29d. Date signe	ed (Month, Day, Year)
			30 Name and address of person who o	ompleted cause of death (Item	n 23a) (Tune	DOC	15624	0	Viciembr	cr 11,2005
_	1		30. Name and address of person who co	D Umms >2	2-5. GA	cerest,	Bathu	none Mis	21201	
- SE	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 4 2	JZ. Progistial 3 Sigila	ature .	A				

Margolis, Melvin Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			pe or Print in Blac					
	4	For State	State of Maryland /	Certificate		2		0328
		Registrar 1. Decedent's Name (First, Middle, Last)		Oertinicate c	Death	Reg. No.	J U U "Y	3. Time of Death
Physicia	n	MELVIN		MARGOLI	S	December		0900 AM
/Medica Examine		4a. Facility Name (If not institution, give str	eet and number)		n, or Location of Death		County of Death	0 100 1.
LAdimire		Sinai Hospital	of Baltimo	re Bal	timore (ity		N/A
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) If Under 1 You Months Da	ear If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthpla Countr	ce (State or Foreign
Director	-	222 20 0000	^{1 2□ F} 93	Yrs.		01/03/1912		" MD
and	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location			10	d. Inside City Limits
the Maryland	ō	MD N.	/A BALT	TIMORE				Y☐Yes 2☐No
ith the	Director	10e. Street and Number		10f. Zip Coo	de	10g. Citi	izen of What Countr	y?
23a o		3031 FALLSTAFF ROA	AD APT. 507-C		209		U.S.A.	
r dea	Funeral	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - America Black, White, et 	tc.
or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1 ☐ Yes 2 💆			Specify: WH	ITE
hour tural	9 0	15. Decedent's Educa	Year or Dates:	a. Decedent's Usual O	ccupation	16b. K	ind of Business/Indu	ıstry
n "na	plet	(Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of work do life. DO NOT use re	one during most of work etired)	ang		•
d with	Completed	12	College (1 401 317)	PROPRIETOR		FURN	ITURE & A	PPLIANCES
al Hy s other	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Maiden	Sumame)	
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I warked other than "natural", or teme 23a or 28a-f show umatic event, it a Medical Exertifier must be invitited at	၉	JOSEPH		MARGOLIS	EDITH			BLUM
C1 40 = 40		19a. Informant's Name/Relationship (Type	,,	,		RE, MD 2120		iode)
1 and Health Brn 27 ther tr		GAIL H. MARGOLIS/	20b. Place	of Disposition (Name of	of		ocation - City or Tow	n, State
Pages nent of 1 int: if its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re	noval from State	tery, crematory or other	r place)	09/2005 FIN		
artme ortani injury	- 1	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		JACOB CONG. 22. Name and A	ddress of Facility			
permit. Departimport any in) land		0000 051		L LEVINSON (ROAD - PIKE		
TEN		23a. Part1. Enter the disease, or complications, or heart failure. List only one	ations that caused the death. D	o not enter the mode of	dying, such as cardiac	or respiratory arrest.		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Sepsis					Onset and Death
/Medical		resulting in death)	Due to (or as a consequence	pe of):				
Examiner		Suguentially list conditions b.	Puenun	oma				
pe is	Examiner	Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	:e :1):	KERLEL	2		THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TW
be executed ician and burial-transi	хап	that initiated events c. resulting in death) Last	Due to (or as a cons see end	pe of):				
bur	<u>a</u>	d						
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physiclan/Medic							
h cert endin	an/N	23b. was decedent pregnant	c. If yes, outcome of pregnancy	ath 3 Ectopic pregn	nancv		23d. Date of deliver	
o deat	sicie	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown				Month [Day Year
d by t	Phy	9 ☐ Unknown Part II. Other significant conditions cont.	ributing to death but not resulting	n in the underlying caus	e given in Part I	23e. Did tobacco	use contribute to the	cause of death?
ires the signer signer is be d	þ	Patti. Other significant conditions cont.	losting to dodin but not resolution	g in the underlying ouds	o good at t cott,		□No 3□ Proba	
requ been shouk	Completed					24a. Was an	24h Were auton	sy findings available
The law ate has page 2	m l			-		autopsy performed?	prior to com death?	pletion of cause of
	CO	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 ☑ No th Check only one	1 ☐ Yes	100
Attending Physician: r death. ector: After this certific by the funeral director,	0 0	examiner?	spital: 1 Inpatient 2 ER/	Outpatient 3 DOA	Other	ome 5 Residence	6 ☐Other (Specify	,
ig Physical distribution	T:U	27. Manner of Death 1 M Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28t	b. Time of 28c.	Injury at Work?	28d. Describe how inju	ry occurred	
endir eath. or: Af he fu	satic	2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No			
or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, of	ffice	28f. Location (Street ar City or Town, State		Route Number,
pital ours a		29a. Certifier 12 Certifying Physi	cian: To the best of my knowled	dge, death occurred at t	he time, date and place	and due to the cause/s) and manner as st:	ated.
24 ho 24 ho Fun	Medical	(Check only 2 Medicel Examination one)	er: On the basis of examination and manner stated.	and/or investigation, in	my opinion, death occu	rred at the time, date an	d place, and due to	the cause(s)
To the Hospital or Attending Ph within 24 hours attendered to the Funeral Director After thi completely filled in by the funeral	Me	29b. Signature and title of certifier	<i>f</i>	29c. L	icense number		te signed (Month, L	
r s r ō		1 Amai	lul	D	2225	y Dera	ember 12	2005
10/2		30. Name and address of person who cor	npleted cause of death (Item 23	a) (Type, Print)	1		ח וו	1
Y		ADRIAN	morein	- MD	Singi H	y Dece ospital of	Da Hime	re
Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 20	32. Registrar's Signature	Marke				
riegisti	GI	DEC TO TO	1					

DHMH 17 Rev 1/2001

Rhonda Preston 05-08196 NJM

		_	1 - For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of <i>rtificate o</i>			iene •g. Ng. () () (5	40329
	Physici /Medio		Decedent's Name (First, Middle, Las Rhonda	(1)	Prest	on		2. Date of Deat Month December	Day Year	3. Time of Death 0919 M
	Examin Funeral Director	_	4a. Facility Name (If not institution, give Good Samaritan H 5. Social Security Number 6. Security Number 11	ospital 7. Age	(In yrs. last birthday) 43 Yrs.			8. Date of Birth	Year) Cou	nplace (State or Foreign intry) 11gan
	yiand how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	the Ma	Director	Md. NA		Balti	More)	1	0g. Citizen of What Cou	1 XYes 2 No untry?
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036	72 hours after deeth with the Maryland natural', or Iteme 23a or 28e-f ehow dical Examirar must be codified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:		If Yes, specify C	f Hispanic Origin? (5 uban, Mexican, Puel lo <i>Specify:</i>	to Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
21215-0036	within ene. then "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	ucation de completed) College (1-4or5+ 1 yr	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo red)	orking	16b. Kind of Business/l	ndustry
and 2	be filed stal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last) Gray		Preston	embroλe(me (First, Middle, M	Maiden Sumame)	
Maryland	d 2 should be th and Mental 7 ie marked c treumatic ev	Ţ.	19a. Informant's Name/Relationship (7			ng Address (Stre			Castronovo , City or Town, State, Zi	
Baltimore, M	of Heeli of Heeli litem 2		Christine Edmunds 20a. Method of Disposition 1 Burial ZCTernation 3 D 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo cemetery, crea				20c. Location - City or T	
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68760,	Physician per specured by Medical Examiner and the purist-transit is the purist-transit.	edical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pulminer Due to (or as a Den VIII D to (or as a	71. 1	ar Gelism	It Leg			Interval Between Onset and Death
.O. Box	The law requires that the death certific to has been signed by the ettending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnal	псу		23d. Date of delik Month	very Day Year
Q	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	inderlying cause	given in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	J
of Vital Records,		Completed						24a. Was a autops perform 1 X Yes 2	y prior to c	opsy findings available ompletion of cause of
f Vit	Physicien: This certificer	To Be	25. Was case referred to medical examiner? 1. ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2 FVOutpatie	nt 3 DOA	Other	ath <i>Check only on</i> Home 5 ☐ Reside	ence 6 Other (Spec	ıfy)
	ending Ph sath. or: After th he funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Year) 28b. Time o	V	jury at Vork? □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	To the Hospital or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ry - At home, farm, st (Specify)	reet, factory, offic	C6	28f. Location (St. City or Town	treet and Number or Rui n, State)	ral Route Number,
	se Hosp 24 hou ne Fune sletely fil	Medical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysicien: To the best o liner: On the basis of and manner stat	examination and/or in	h occurred at the evestigation, in m	time, date and plac y opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	1-4.		29c. Lice OCMI	nse number		9d. Date signed (Month	
1	1		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,			1	December, 6	, 2005
-	1 Str	ate	THEODOREM (King 31. Date filed (Month, Day, Year)	32#Registra	r's Signature	111 1	Penn Stree	et Balti	more, Maryl	and 21201
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ndre,			20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, crer LLY Hil	sition (Nam	ne of ther place)	1	Date	20	c. Location - C	-	
Baltimore	permit. Page Department i Important; if eny injury or		21. Signature of Funeral Service Licen:		22	. Name an	d Address	of Facility		unek	Funeral	2 Homes	
8760,	Physician / Medical Examiner provided the prival-Itansit	dicai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that caused the deane cause on each line. a. Due to (or as a consect to the consect	due to equence of):	Van		Kin-	Resista			Inter	oximate val Between et and Death
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Z X	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2[☐ ER/Outpatier	at 3 DO	Other		of Death Checrosing Home 5		ce 6 □Other	(Specify)	
	ding h. After fune	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury a Work? 1 🗆 Ye		28d. De		injury occurred		
Division	i Dia	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		eet, factory	, office		28f. Lo	cation (Stre ty or Town,	et and Number State)	or Rural Rou	te Number,
	H 4 h	edicai (29a. Certifier Certifying Phyone) 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred a vestigation,	at the time	, date and nion, deat	d place, and du h occurred at th	e to the cau ne time, date	se(s) and mani e and place, an	ner as stated. ad due to the c	cause(s)
) ,	To the within 2 Complet	Me	29b. Signature and title of certifier	~ MD			License r		7)	290	1. Date signed	(Month, Day, 1	Year)
je	5		30. Name and address of person who o	ompleted cause of death (Ite	em 23a) (Type,	Print)	3		orive, R	011.	n (n 14	110 2.0	77
	Sta Registi		31. Date filed (Month, Day, Vear) DEC 1 4 200	32, Registrar's Side	tature		yvai	12 11	The E	XULTIY	NOIG N	110, 210	13/

Amend item#16a-b, perFH, C850, 12/19/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** DECEMBER 94, 20125 10:35P Pinson Clarice /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Yrs. | Yrs. | Hours | Min. | O 9 2 6 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2X F 238-50-2753 34 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "natural", or items 23a or 28a-f shov the Medical Expriment past be putified at 1 ☐ Yes 🌠 No Directo MD Pikesville Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21208 8139 Scotts Level Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wireman Sortir 12th grade Westinghouse Defense na other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be it Department of Health and Mental F Important: if Item 27 is marked of eny injury or other treumatic ever eny injury or other treumatic ever Pages 1 and 2 should be nent of Health and Mental Lula McMillan 2 William G. Maultsby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) 8139 Scotts Level Road, Pikesville, Md Phyllis Maultsby-Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 12/16/05 Baltimore Co, Md 21. Sinceture of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md Pyrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Imm diate Cause (Final dise se or condition resulting in death) Onset and Death Physician ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner MONTHS ANEMIA ACUTE ON CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit or Attending Physician: The law requires that the death certificate be executed physicien and Due to (or as a consequence of) O. Box 68760. Physiclan/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown Division of Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DEMENTIA 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an has certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To epatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Magner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. M 1 ☐ Yes 2 ☐ No naral Director: A filled in by the fo investigation 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier P. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D25886 1 eted clause of death (Kem 23a) (Type, Print) MARYLAND 21204 OSLER DRIVE TOWSON, 7601 31. Date tiled Month, Day, Vear) DEC 1 4 2005 76 VI 1 13 State

Registrar

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Exami		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location o	f Death		4c.	County of Deat	th	
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Funeral		5. Social Security Number 6. Sex	7. A		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird	th v. Year)	9. Birt	thplace (State	or Foreign
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and *		Usual Residence of Decedent 10a, State 10b, County		10c, Cit	ty, Town or Lo	cation							10d. Inside C	tity Limits
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death ms 23	Funerai Director		12. Was Deceden	t Ever în U	.S. 13. V	Vas Deced	ent of Hi	spanic Orio	in? (Spe	ecify Yes or No		14. Race - Ame	nican Indian.	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23e or 28a-1 show any injury or othar traumatic avant, it a Modical Examination in the invitited at any filed.		21. Signature of Funeral Service License	90	OLI	thodox							LIMOLE	Maryra	Hu
Deparming Department of the police.		Thomas Gregor	0		Y	acNab	b Fi	inera.	l Ho	me, P.A	xzi 11	e, Mary	and 2	1228
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To the Hospital or Attanding Physician: The law requires that the death certif within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Med													
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()	1	30. Name and address of person who co	mpleted cause of	death (Iten	n 23a) (Tvna I	Print)		316	>			- N	D 217	21
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MARGARET J. ROBERTS O5-8324 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PII, per/ME, C855, 5-1, 100 TI

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					E HOSPITAI		. last birthday)	ROSI	EDALI	E If Under	24 Hrs	9. Data of Rid		LTIMOR	E irthplace (State	Cruzina
	Funeral Director		5. Social Security 217–40–8	3054	1 □ M 282NF	62	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 10-13-1	1943	Per	nnsylvar	iia
	and #		Usual Residence 10a. State	of Decedent 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside C	City Limits
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21	led will lygien her th	Con	12				Home	Maker						Home		
Maryland	uid be fi Mentaj H arked ot	To Be	Alpheus	e (First, Middle, Linthicu	•						ers Name .s Her	(First, Middle, nry	, Maiden :	Sumame)		
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}	Physician /Medical		23a. Part f. Ente shock, or h Immediate Caus disease or condi resulting in deatl	ition	complications that only one cause of a	aused the des	th. Do not an	ter the mod	e of dying	g, such as	cardiac or scale	respiratoryal	rrest,	Se	Approxima Interval Be Onset and	tween
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8760,	cate be executed physicien and the burial-transit	dical E			d	(0. 20 2 00.100										
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	requires that the een signed by th nould be detache	d by Pi	Part II. Other sig	nificant condition	ns contributing to d	eath but not re	sulting in the u	nderlying ca	ause give	en in Part I.		1	obacco us		to the cause of	death? Únknown
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al R	The ate h page	Com											ormed?	prior to ? Ye		cause of
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of	g Phys er this erel di	n: T	15 Yes 2 27. Manner of De	eath	28a. Date	Inpatient 2 [of Injury th, Day Year)	28b. Time o		8c. Injury Work	4 🗆 140		ne 5 Resid			ecify)	
Sion	Attending r death. sctor: After by the fune	atio	1 Natural		ation CA	LI, Day rear)	Injury	M	1 🗆 Y		No	Sulpie	id e	MUYE	ed 18	#
Division	or Att	Certification;	3 Suicide 4 Homicid	6 ☐ Could r determ	ned 288. Place	of Injury - At ling, etc. (Spec			, office		2	City or Tov	Mn State)		Rural Route Nun	n <i>ber,</i>
_	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funerel	Medicai Ce	29a. Certifier (Check only	1☐ Certifyin	g Physician: To the Examiner: On the b	asis of examin	nowledge, deat nation and/or in	h occurred	at the tim	e, date an pinion, dea	nd place, a	nd due to the	cause(s) a	and manner a	as stated.	(221
	To the within ? To the comple	Mec	29b. Signature a	nd title of certifier	and man	ner stated.	\			number					nth, Day, Year)	
	/7/		1)/	Certe	ens)		0	CME		I	DECEM	BER 10	, 2005	
			30. Name and ac	Lew Son	who completed caus	4 0	em 23a) (Type, L11 PEN		TEET	ват.т	TMORT	E. MARV	/T.ANI	2120)1	
	Sta , Registi		31. Date filed (M	onth, Day, Year)	1 2005	egistrar's Sigr		Seek)	,			-,		, 2:20		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** REVELL EDWINA 8:10 AM 10, 2005 DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOS PITAL BALTIMORE HARBOR CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2 F Hours 229-44-4715 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 2 amon 04 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ack 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic DUSE 3rd WIFE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MIPLDS xx rah 19a. Informant's Name/A lationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other training. 3043 JUNIOR md, 21225 Daughter acto 2a mon 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) meters 21. Signature Juner | Service Lice 22: Name and Address of Pi cility Balting. 23a. Part1 Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate/Cause (Final disease or condition resulting in death) Priysician HYPERCAPNEIC RESPIRATORY FAILURE 48 hours /Medical Due to (or as a consequence of): **Examiner** ASPIRATION PNEUMONITIS Esquartially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ACUTE FAILURE KENAL Due to (or as a consequence of): Box 68760, DEHYDRATION IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Yes 21 No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 1 Impatient Medical Certification; To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No investigation 2 Accident 24 hours after deatl Funeral Director: Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

Dr. ADJEI

SOUTH HANOVER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

M. ADJE 1

ABDUL

RES 000

STREET

DECEMBER 10, 2005

BALTIMORE, MARYLAND 21225

			1 - For State Registrar	State of	f Maryla	nd / Depa	artmen rtificate	t of H	lealth a	and M	ental Hy	/giene	005		40336
	Dharatat		1. Decedent's Name (First, Middle, Las	t)							2. Date of Do				3. Time of Death
	Physicia /Medic		Mary C. Reese								12	06			2:45P M
	Examin	er	4a. Facility Name (If not institution, give	street and nun	nber)		_		Location o	f Death		4c.	County of D	eath	
			9417 Falls Road		* • · · //- · · ·		Poto		If Under 2	0.4 Hen			lontgo		-
ı	Funeral Director		243-12-0000	M 2 K LF	7. Age (in yrs	s. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D 5 / 29 / 1	lay, Year) L917	9.	Coun Ort	lace (State or Foreign htry) h Carolina
	land	1	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1:	0d. Inside City Limits
	Mary f sho	호	MD Montgome	rv	Po	tomac									1 Yes 2 No
	r 28e	Funeral Director	10e. Street and Number	L y		Lomac	10f. Zip	Code				10g. Cit	izen of What	Coun	itry?
	h with	al D	9417 Falls Road				208	54				USA			
	от де в	ner	11. Marital Status	12. Was Dece Armed Fo	dent Ever in	U.S. 13.	Was Deced	lent of Hi	ispanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race - A		
2	or It	교	1 ☐ Never Married 2 ☐ Married	1 □ Yes If Yes, Giv	2 2 100		1 ☐ Yes	1 4	Specify:	, 1 001101	ticari, etc.)		Black, V		
Ś	urel'	d by	3 Widowed 4 □ Divorced	Year or Da	ates:										
2	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usua kind of wor DO NOT us	k done c	lurina most	of working	ng	16b. K	ind of Busine	ss/Inc	lustry
7	iene.	E O	Elementary/Secondary (0-12)	College (1	-4or 5+)	House			,			Δ÷	Home		
2	il Hyg other	Be C	17. Father's Name (First, Middle, Last)			, 110000			18. Mothe	r's Name	(First, Middle				
0	Aenta Aenta rked ric ev	To B	Hamilton Brust Re	ese					Mary	Eliz	abeth	Conr	ad		
2	and Name		19a. Informant's Name/Relationship (1					l Route Numb	-	r Town, Stat	e, Zip	Code)
, E	and 2 salth n 27 I		Elizabeth Reese/D	aughter		_				omac	, MD 2	0854			
ב	of He of He of He or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from :	20b.	Place of Dispo cemetery, cres	nsition (Nan	ne of ther plac	θ)	D	ate	20c. Lo	cation - City	or To	wn, State
	Pag Iment tent: jury o		`4 ☐ Donation 5 ☐ Other (Specify		Ch						-2005	Belt	sville	, l	MD
Dalimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturet", or items 23a or 28a-f show any Injury or other treumetic event, the Habital Examination must be multiped at once.		Chesapeake Crematory 12-13-2005 Beltsville, MD 21. Signature of Funeral Service Licensea Rapp Funeral & Cremation Services 933 Gist Ave.												
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	a	ach tine. Oke or as a conse	equence of):		e of dying	g, such as (cardiac o	r respiratory a	arrest,			Approximate Interval Between Onset and Death
,00,00	To the Hospitel or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The thin 25 hours after death this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		e		***************************************						
O. DOX O	uires that the death certifica signed by the attending pt d be detached for use as t	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		inth 2 ☐ Fei ant at time of	tal death 3□	Ectopic pro						23d. Date of Month		ry Day Year
Olds, T	quires that n signed by	by	Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the u	nderlying ca	ause give	en in Part I.			tobacco u			e cause of death?
ממט	stcian: The law requir s certilicate has been si lirector, page 2 should	Completed									24a. Was auto perfe 1 Yes		prior	to con	osy findings available inpletion of cause of
2	Physician: The this certificate har director, page	BeC	25. Was case referred to medical examiner?								(Check only	опа)			
5	hyslo his ce il dire	은	1 ☐ Yes 2 KNo			☐ ER/Outpatien		A Othe	er: 4 □ Nur	rsing Hon	ne 5 Resi	idence (5 □Other (S	pecify)
	anding Physiath. or: After this ne funeral di	atlon;	27. Manner of Death 12. Natural 5 ☐ Pending 2 ☐ Accident investigation	1	of tnjury h, Day Year)	28b. Time of Injury	f 2	Bc. Injury Work	rat ⟨? Yes 2∐N	2	8d. Describe	how injur	y occurred		
	tel or Attencts after death	Certification;	3 Suicide 6 Could not be determined	28e. Place	of Injury - At I ng, etc. <i>(Sp</i> ec	home, farm, str cify)	eet, factory	, office		2	8f. Location (City or To	(Street an wn, State	d Number or)	Rural	Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	ysicien: To the niner: On the ba and mann	asis of examir	nowledge, death nation and/or in	h occurred a vestigation,	at the tim	e, date and pinion, deat	d place, a	nd due to the	cause(s) date and	and manner place, and	as sta	ated. the cause(s)
	To t. To til comp	M	29b. Signature and title of certifier	Then ?	Sald!	TUD			number				e signed (M		Pay, Year)
	- 1				/		100	3472	6 MD			12-	9-2005		
	70		30. Name and address of person who Jasmine Gatti 821	_				MD	20813	3					
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 4 200	2200	egistrar's Sign										
				7-4											

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Ma	aryland		artment of F tificate of			giene Reg. No. 005	40337
	Physicia	n	1. Decedent's Name (First, Middle, L LOIS L. RAMSEYER						2. Date of De Month DEC	ath Day Ye 11 2005	M
}	/Medic Examin	_	4a. Facility Name (If not institution, gi		WOODS		4b. City, Town, o	Location of Death		4c. County of D	eath
	Funeral Director			Sex 7. Ag	e (In yrs. lasi 83	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 3		Birthplace (State or Foreign Country) PA
	and		Usual Residence of Decedent 10a. State 10b. County	<u>. </u>	10c. City, T	Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	Maryland Baltimo	re		Ba:	ltimore C	County			1 □ Yes 2√√No
	r 28s	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	t Country?
	23s c	raiD	7656 Gumspring F				1	21237		USA	Anna ta dina
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other than "natural", or items 23e or 28s-f show or other traumatic event, Ita Medical Eracinal must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married X3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes X2 If Yes, Give Year or Dates:	•	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2√√ No	lispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Black, V	American Indian, Vhite, etc. White
Maryland 21215-0036	"natural	Completed b	15. Decedent's (Specify only highest s	Education rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Busine	ess/Industry
12	e filed within al Hygiene. I other than "	omo	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)		ce Admini			Business	Services
br	be filed tal Hygid d other event, I	Bec	17. Father's Name (First, Middle, La.	st)						, Maiden Surname)	
ylaı	ould be I Mental parked o	To E	Frank William La							andsperger	
Mar	12 sho h and 7 ie ma trauma	1	19a Informant's Name/Relationship Marian L. Wilson							er, City or Town, Sta , Md . 2123	
	is 1 and 2 of Health item 27 i		20a. Method of Disposition	(013001)	20b. Plac		sition (Name of matory or other plan	-	Date	20c. Location - City	
OE.	Pages nent of I ant: If it		1 🖔 Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Special Control of Co				of Faith		4~2005	Baltimo	re, Md.
Baltimore,	permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service Lice	es chr		22	Lassahn 7401 Be	Funeral	Home Baltimo	ore, Md. 2	1236
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each I	d the death. ine.	Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest.	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Mult	ple	W	lyelow	NA.			4
	/Medical Examiner		100aking in down,	Due to (or as	a conseque	nce of):	0				
	,A	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	nce of):					<u> </u>
V	cuted nd transit	Examiner	Cause (Disease or injury that initiated events	C							
,0928	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):					
687	ificate g phys as the	edical		d							
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal d	eath 3	⊒Ectopic pregnanc ∃ Other (specify) _	у		23d. Date of Month	f delivery Day Year
Ω	quires that in signed b uld be deta	by	Part II. Other significant condition	s contributing to death	but not result	ing in the u	inderlying cause gr	ven in Part I.			te to the cause of death? Probably 4 Gunknown
Records,	The law requir cate has been si page 2 should	Completed							24a. Was auto perfe 1 ☐ Yes		
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hagaital:			Ott		ath (Check only		
of	d s	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpat		R/Outpatie	nt 3 DOA	4 Kur ursing F		idence 6 Other (Specify)
On	fter	tion	1 Avatural 5 Pending 2 Accident investiga	(Month, D	ay Year)	Injury	Wo	rk?]Yes 2 □ No		,,	
Division	or Atter after dea Director in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. FIAUG UI II	njury - At hometc. (Specify)	ne, farm, st	reet, factory, office			(Street and Number own, State)	or Rural Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical Ce	29a. Certifier Certifying (Check only one)	Physician: To the best taminer: On the basis and manner s	of examination	ledge, deal on and/or in	th occurred at the ti	me, date and place opinion, death occi	and due to the urred at the time.	cause(s) and manne , date and place, and	or as stated. due to the cause(s)
	ro the	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date signed (A	fonth, Day, Year)
	- >- 0		V.V	~		WI		053462		12/12/01	
	12		30. Name and address of person w		death (Item 2	23a) (Type	Print)		- ~	1	0.
	10		31. Date filed (Month, Day, Year)		845 trar's Signatu	NAK	woold R	08d G	len 1271	nie Wi	7 31061
	St Regist	ate rar		2005			Garte				_

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		•	For State Registrar					rtificate				-	Reg. No) [0338	
	Physici	3.0	Decedent's Name (First, M	iddle, Last)								2. Date of De	ath Day	, Y	ear	3. Time of Death	
	/Medic		BETH					RHOP	P			DECEMBI	er 8	20		1158 A M	1
	Examin		4a. Facility Name (If not institu							Location o	6	141/	4c.	County of i	Death		
	uneral	· ***	THE JOHNS 5. Social Security Number	6. Sex		toSPITA 7. Age (In yrs	اــا . last birthday)	If Under	1 Year	MORE If Under:	24 Hrs.	8. Date of Bir	th	9	Birthpla	ace (State or Foreign	
	irector		220-74-2144	1 🗆	M 2XF	36	5 Yrs.	Months	Days	Hours	Min.	$J_{un}^{(Month} 5)$	^{iy.} 196	9	Mary	land	
pu	> 0		Usual Residence of Decedent 10a. State 10b. Cou			10c C	ity, Town or Lo	ocation							10	d. Inside City Limits	
Maryla	o a b	৳		Freder	rick	1.00.0	Frede								10	1 ∑ Yes 2 ☐ No	
the	7.28a	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of Wha	at Count	ry?	_
th with	238 0	alD	900 Motter A	venue						21701				U.S.	Α.		
r deal	er II	Funeral	11. Marital Status	1:	2. Was Dece Armed Fo	edent Ever in l	J.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Black.	America White, e		
36 s alte	, o	by Fu	1 ☐ Never Married 2 ☑ I 3 ☐ Widowed 4 ☐ Divor		1 ☐ Yes If Yes, Giv Year or Da	re		1 ☐ Yes						Specify:	T.Th	ite	
5-0036 72 hours alter death with the Maryland	atural G E			dent's Educ		a165.	16a. Dece	dent's Usua	al Occupa	ation			16b. K	ind of Busin			
1215 within 73	Ward Ward	Completed	(Specify onfy his Elementary/Secondary (0-1		Completed)	-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	du <i>ring</i> most !)	t of worki	ng				•	
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Maryland 21215-0036 Id 2 should be filed within 72 hours all the and Merial Hydiene.	in any works type of the "naturel", or leme 23s or 28s-f show traumatic event, the Madical Examinar must be notified at	To Be	17. Father's Name (First, Mid Louis A	Albert	F	inneyf	rock			Jud		e (First, Middle Ann			eem	an	
Mary nd 2 sho	27 is ma r trauma		19a. Informant's Name/Relat Reginald Wayr	ionship <i>(Typ</i> ne Rho	ades,H	lusband						al Route Numb edericl					
Baltimore,	if Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 XX remati	ion 3∏Be	amoval from		Place of Disponentery, cre	matory or o	ther place	ө)		Date		ocation - Cit	•		
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ox 68	attending phy I for use as th	Physician/Med	IF FEMALE:	. 23	3c, If yes, out	come of prega	nancy					,		23d Date o	of dollaro		
Box Jeath cert	atten d for u	clar	in the past 12 months? 1 Yes 2 No	'	1∏Live b 4∏Pregn	oirth 2 ☐ Fe nantattime of	tal death 3	□Ectopic pr □ Other (sp						23d. Date o Month		y Day Year	
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Re a	page 2	mo											ormed?	prio dea	r to con th?	pletion of cause of	
	certifical rector, p	BeC	25. Was case referred to me	dical						26. Place	of Death	1 Yes	2 □ No one)		105	2/140	
of Vita Physician:	. <u>v</u> ⊕	2	examiner? 1 Yes 2 No	H	ospital: 1	Inpatient 2 (☐ ER/Outpatre	nt 3 DC	Othe Othe	er: 4 ☐ Nu	ırsing Ho	me 5□Res	idence	6 □Other	(Specify)	
	Vfter	ii o	27. Manner of Death 1 Natural 5 ☐ Pe		28a. Date (Mon.	of Injury th, Day Year)	28b. Time Injury		28c. Injun Worl	k?		28d. Describe	how inju	ry occurred			
Division For Attending	Director: A	cat	3 ☐ Suicide 6 ☐ Co	vestigation ould not be	28e Place	of Injury - At	home, farm, s	M Ireet factor		Yes 2 🔲	No	28f Location	(Street au	nd Number	or Rural	Route Number.	
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Division To the Hospital or Attending	within 24 hours after dear To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Cert (Check only one) 2 Med	tifying Phys lical Examin	er: On the b	a best of my ki asis of examin ner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the time, in my of	ne, date an pinion, dea	d place, th occur	and due to the ed at the time	cause(s date an	and mann d place, and	er as sta d due to	ated. the cause(s)	
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,	5		30. Name and address of per JOHN APOSTOL		mpleted caus	1 1000	LINI	06 5	REE	T, BA	LTIM	OPLE	MAR	9LAND	2	1287	
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			1 - State of Maryland State of Maryland		artment of He rtificate of D		Mental Hygie		40339
	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Frances Louise	Ruth			Dec. 8	2005	9:40pM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Dea	th	4c. County of Death	
			531 46th Street		Baltim			Baltimo:	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. № 21.4 5.6 7.0.45 1□M 3♥F		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birth	place (State or Foreign ntry)
	Director		214-30-7043 55	Yrs.			Dec.3,1	950 Wes	tVirginia
	and w	}	Usual Residence of Decedent 10a. State 10b. County 10c. City	. Town or Lo	cation				10d. Inside City Limits
	Aaryl f sho	ō	MD Baltimore		Baltimo	ro			1 ☐ Yes 2 ☑ No
	the A	ect	10e. Street and Number		10f. Zip Code	1.6	100	. Citizen of What Cou	
	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or Items 23e or 28e-f show ent. Ite Medical Examiner must be notified at	Funeral Director	531 46th Street		2122	и	1.09	USA	110 9 2
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.	3. 13.1	1		Specify Yes or No-	14. Race - Ameri	can Indian.
' O	r Iter	F	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puè	to Rican, etc.)	Black, White	
ဗ္ဗ	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1□Yes 2□No	Specify:		Specify: W.h	ite
21215-0036	72 ho	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupati	ion	161	o. Kind of Business/Ir	ndustry
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yla	2 should be and Mental Is marked o	ပ	Robert C. Goodnow			Avis F	K. Bennet	t	
Maryland	2 sh and ls m		19a. Informant's Name/Relationship (Type, Print)				ural Route Number, C		o Code)
	and sealth m 27		James W. Ruth /son			e Way	Baltimor		
ore	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. Inter 27 Is marked other then "natural", or Items 23e or 28a-f show int: If item 27 Is marked other then "natural", or Items 23e or 28a-f show iry or other treumatic event, Ite Medical Examiner must be notified at		20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State	ace of Dispo metery, crer	sition (Name of natory or other place)	i		c. Location - City or T	
Baltimore,	Part ury		`4 □Donation 5 □Other (Specify)	kLawı	nCemeter	y 12	/13/05 B	altimore	MD
3a	permit. Departr Import any inji		21. Signature of Funeral Service Licensee	22	. Name and Address	of Facility C	onnellvF	uneralHo	meofEssex
	707 a 0		1. July onnell	4	300 Mag	ce Ave	. Baltime	ore MD 2	1221
١.			23a. Part1. Enter the disease, or comblications that caused the death shock, or heart failure. List only one cause on each line.	onot ent	er the mode of dying,	such as cardia	c or respiratory arrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	ana	4				Onset and Death H Wars
	/Medical Examiner		resulting in death) Due to (or as a) nsequence.	ence of):					
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	ed isit	nine	cause. Enter Underlying Cause (Disease or injury	erice or _j .					
9	cate be executed physician and the burial-transit	Examine	that initiated events c. resulting in death) Last Due to (or as a consequ	ence of):					
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687	ficate physis the	Physician/Medical	d						
Вох	centi nding use a	W/C	IF FEMALE: 23c. If yes, outcome of pregnant	псу				23d. Date of deliv	erv
	death atte	ciai	in the past 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)			Month	Day Year
o.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	nysi	9 ☐ Unknown						
S,	s that ned b		Part II. Other significant conditions contributing to death but not result	fting in the u	nderlying cause given	in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
5 S	quire nn sig uld b	q pa	Cervical cancer diagnos	ed 1	996		1 Yes	2 □ No 3 □ Prol	pably 4 □Unknown
Vital Record	aw requir s been si 2 should l	Completed by	0				24a. Was an	24b. Were auto	ppsy findings available
Re	The la	mo					autopsy performed	1? death?	mpletion of cause of
<u>a</u>	en: tiffica tor, p	0	25. Was case referred to medical			26 Place of De	1 ☐ Yes 2 X	No 1 ☐ Yes	2 No
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0	g Ph ter th neral		27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury a Work?		28d. Describe how i		//
Division of	ath. r: Aff	Certification;	2 Accident investigation	Hijary		s 2 No			
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	To the Hospitel or Attending Physicien: The tawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examinat	vledge, death	occurred at the time,	, date and place	e, and due to the caus	e(s) and manner as s	tated.
	the him 24		and manner stated.				oriod at the time, date	and place, and due to	o tile cause(s)
	To To To	Σ	29b. Signature and title of certifier		29c. License r			Date signed (Month,	,
•			Volga, m)		DOG	5134	19	12/12/	12005
			30. Name and address of person who completed cause of death (Item	23а) (Туре,	Print) Q	00+ -	19 101, m)	2:2-	
			910, Franklin Square Dr S	vite -	20) D	out in	way, my	01237	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 4 2005 32. Registrar's Signat	ure					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 15 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** Neodore STEWANT 2:30 Reember 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A KESWICK NURSING HOME If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Yrs. Director 95 263-16-1231 29 1910 APR. MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at 1K Yes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? U.S.A. 1701 EUTAW PLACE **APT 1010** 21217 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 42/45 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mental and ODGE. Black, White, etc. 1 Never Married 2 N Married 1 ☐ Yes 2 ☒ No Specify: à Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 42/45 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) McCORMICK SEASONING DISTRIBUTOR 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ ROBERT A STEWART LUCY HARPER STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes L. Stewart/Wife 1701 Eutaw Place Art 1010, Baltimore, Md., 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 12-14-05 BALTIMORE, MARYLAND 21. Sign turn of Funeral Service Licen 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CISEASE VASCULAY disease or condition resulting in death) Due to (or as a consequence of): pertension Sequentially list conditions, if any later cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dinmine warthri 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes → No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one)

Pnysician /Medical Examiner The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760, attending physician

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s after death.
It Director: After this of in by the funeral d

filled

Medicai

or Attending Physician:

Hospital

To the

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death

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

within 24 hours a 11

Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) north CHAVIED Donm. 7. 5901

29c. License number

35102

Strew Baltimore

29d. Date signed (Month, Day, Year)

2005

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32, Registrar's Signature 2005

and manner stated

State of Maryland / Department of Health and Mental Hygiens 40341 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12 **Physician** 12-13-2005 STITH ALBERTA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1324 N. BENTALOU STREET BALTIMORE Under 1 Year If Under 24 Hrs onths Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗓 F Yrs. JAN. 15,1920 DC 85 Director 219-12-2354 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State or 28a-1 show of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Iteme 23s or 23s-1 ehov other treumatic event, the Medical Examination at the Colling at MD 1XXYes 2 □ No BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21216 1324 N. BENTALOU STREET Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 XX Widowed 4 □ Divorced ģ 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) HOME HOUSEWIFE 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth ery july or other treumatic event 908. PALMER EFFIE JAMES PALMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 781 E. HEDDING ST., ST. JOSE, CA 95112 DOREESE DAVIS/FOSTER DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/14/05 BALTIMORE, MD **METRO** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. I gnatule of Funeral Service Licensee 1701 LAURENS STREET, BALTO., MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma of Lung **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) use as the burial-Box 68760, physicien Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown cate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No this certificate : After this certifica funeral director, f or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25 No Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1- Matural 1 Yes 2 No s after death. 2 Accident the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by t determined 4 Homicide To the Hospital within 24 hours a To the Funeral C pelli Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number of certifier 29b. Signature and D18327 4660 helters Ave #203 Balto ma 21229 o completed cause of death (item 23a) (Type, Print)

State

Registrar

30. Name and address of berson v

31. Date filed (Month, Day, Year)

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32. Redistrar's Signature

				ate of Death	Reg. No. 115 1.031.2	
	Physici		1. Decedent's Name (First, Middle, Last) (Uarren Simps	Mon	e of Death 1th Day Year 3. Time of Death 12 13 3 M	A
	/Medic Examir			ity, Town, or Location of Death	4c. County of Death	_
		ès,	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Un	cultimore	NA	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un Mont	der 1 Year If Under 24 Hrs. 8. Date hs Days Hours Min. (Mon	e of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) 7. 14,1954 Manual	n P
	D *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits	
	28a-f show	tor		timeso!	1X Yes 2 □ No	
1	oeam with the maryland ms 23a or 28a-f show finals be collified at	Director	10e. Street and Number 2904 ROCK TOCK AVE 10f.	Zip Code	10g. Citizen of What Country?	
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	min reges I and 2 should be lied whim for hours after death with the maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "netural", or Items 23a or 28a-1 abov any injury or other traumatic event, the Medical Examination must be notified at once.	by	1 Yes 2 No 1 Yes 2 No 1 Yes 3 Widowed 4 Divorced Year or Dates:	cedent of Hispanic Origin? (Specify Yes pecify Cuban, Mexican, Puerto Rican, et a 2 /2 No Specify:	Black, White, etc. Specify: Elack	
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, Mai	and 2 so salth and n 27 is m		Cornelia Butler- nother 2904 K	ockrose Are: B	Number, City or Town, State, Zip Code) weto, md, 2/2/5	
altemore	ent of He ant: If Iter ry or oth		20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Name of Date or other place) 12/17/05	20c. Location - City or Town, State 5 Lundwell, md.	
	Department Important: any injury c			and Address of Facility fred	titution Pass	
	10 5 5 d		23a. Part Enter the disease, or complications that caused the death. Do not enter the	Pimarch runer	al Home Basto, md, 2122	9
p	hysician		Immediate Cause (Final	ode of dying, such as cardiac or respirat	atory arrest, Approximate Interval Between Onset and Death	
ř.	/Medical		disease or condition resulting in death) a. Complication Due to (or as a consequence of):	et angine	a	
	, Amy	Jer	Sequentially list conditions if any, leading to immediate Due to or sia consequence of):			
90000	and I-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
orou,	hysician and the burial-transit	dicai E	d.			
S X	ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
The laure course, P.O. DOX of	been signed by the attending p should be detached for use as i	Physician/Me		pregnancy (specify)	23d. Date of delivery Month Day Year	
ords, T	n signed b	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I, 23e.	. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown	
	as bee	ompleted		24a.	. Was an autopsy findings available prior to completion of cause of	
	ficate t	e Con	OF Was are observed to the first	10	performed? death?	
> .5	is cert	0 8	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient Hospital: 1	26. Place of Death Check	only one! Residence 6 Other (Specify)	-
	To treat proposed or standard or the rest within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M		cribe how injury occurred	-
	vitie nospital or viending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)	
in a House	n 24 hour	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurr 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ad at the time, date and place, and due to on, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)	
, L	withi To the	X		29c. License number	29d. Date signed (Month, Day, Year)	
	0		30. Name and addr. person who completed cause of death (Item 23a) (Type, Print)	359316527 spital of Ba	12/11/05	
	1		Matthew Smith Sing: He	spital of Bo	altmos	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 4 2005 22. Registrar's Signature			

SIMPSON, WONDEN

as

PT. KNOULM

				Pie 1 - State Registrar	ease	State o		ryland / [Depa		f He	alth ar		ital Hyg		05	403	43
	*.	Physici /Medic		1. Decedent's Name (First, Mic Ratko Ivan S		•			-					Date of Dea Month ecembe		2005	3. Time (
		Examin		4a. Facility Name (If not instituted Upper Chesape				enter		4b. City, Town	n, or Lo		Death			unty of Deatl		
		Funeral Director		5. Social Security Number 212–48–7774		Sex 1-√2 M 2□F	7. Age 6((In yrs. last bir.	thday)_ Yrs.	If Under 1 Ye Months Da		f Under 24 Hours	Min.	Date of Birth Month, Day n. 5,	Year)	Co	nplace (State untry) oslavi	-
		aryland show	-	Usual Residence of Decedent 10a. State 10b. Cour	nty			10c. City, Town	n or Loc	ation							10d. Inside (City Limits
		th the M or 28a-f	Irecto	Md. Hat 10e. Street and Number	rfor	:d				Abingd 10f. Zip Cod				1	10g. Citizen	n of What Co		X
Α Δ		eath wi	eral	3512 Thomas 1	Poir	te Cour			13 W	as Decadent	210		n? (Snecify	Vac or No.		Race - Ame	ican Indian	
2756	5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or itams 23a or 28a-f show ther then "natural", or itams 23a or 28a-f show int, it a Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ № 3 ☐ Widowed 4 ☐ Divorce		Armed For It Yes, Given Year or D	rces? 2 🔲 No /e			as Decedent of Yes, specify C		Mexican, F	Puerto Rica	in, etc.)	-	Black, White	e, etc.	
7	15-0	i within 72 hours iene. r then "naturel",	Completed	15. Decec (Specify only hig	hest gr	ade completed)			Decede (Give k	ent's Usual Oc and of work do O NOT use re	ccupatio	on ring most o	t working		16b. Kind	of Business/	ndustry	
	2121	ed withi	Somp	Elementary/Secondary (0-12	2)	College (1	1-4or 5+			s manag					print	ting c	ompany	
\.	land	ld be fill ental Hy ked oth ic sveni	To Be	17. Father's Name (First, Midd Anthony Sikov		")							s Name <i>(Fil</i> a Be r 1	_{rst, Middle,} . nardi	Maiden Sui	mame)		
12/9/05	Mary	and 2 should be filed with patth and Mental Hygiene n 27 is marked other thei ier traumatic svent, ILAA	-	19a. Informant's Name/Relation	onship			19b	. Mailing	Address (Str Howe11	reet and	ourt,	or Rural Ro Abin	oute Number	r, City or To	own, State, 2 1009	ïp Code)	
12/	Baltimore, Maryland	oth Est		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other			State	cemete	ry, crem	ition (Name of atory or other Cremato	place)	1 1:	Date 2/12/			ion-City or		
	Balti	permit. Page Department of Important: if sny injury or once.		21. Signature of Funeral Servi	ice Lice	nsee	/		22	Name and Ad Schimur	ddress 1ek	of Facility Fune	ral H	ome of	Bel	Air,	Inc.	
•	68760,	Physician / Medical Examiner Physician and property Physician and p	Ical Examiner	23a. Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	, or con- list only	a. Due to	ATT (or as a (or as a	the death. Do e.	of):	of the mode of	dying,						Approximation interval Bit (New York)	tween
NAVI	O. Box 68	The law requires that the death certificate I the has been signed by the attending physionage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			oirth 2 nant at t	of pregnancy 2 Petal death time of death		Ectopic pregna Other (specify					23d	Date of deli	very Day	Year
0	م	ires that the signed by	ρ	Part II. Other significant cond	ditions	contributing to d	eath bu	t not resulting in	n the un	derlying cause	e given	in Part I.				contribute to	the cause of	death? Unknown
ATK	Records,	aw require s been sig 2 should b	Completed										_	24a. Was a	an 2	24b. Were au	topsy finding	available
a-	al Re	: The law cate has	Com											autops perfor 1 Yes	med? 2V2 No	death?	completion of 2 No	cause or
110	Vital	Physician: The rhis certificate ral director, pag	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	lical	Hospital:	Inpatier	nt 2□ER/Ou	utpatient	3□ DOA	Other:			heck only or 5 □ Resid		Other (Spec	infu)	
SIKOVIC,	ion of	nding Phys ath. r: After this e funeral dii	atlon: T	27. Manner of Death 1 X Natural 5 ☐ Per	nding estigation	28a. Date (Mon		y 28b.	Time of Injury	28c. I	Injury a Work? 1 Ye		28d.	Describe h				
S	Division	lei or Atte s after de ai Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Coi 4 ☐ Homicide det	uld not ermine	1 280. Place		ry - At home, fa . (Specify)	arm, stre	et, factory, off	fice		28f.	Location (S City or Town		lumber or Ru	ral Route Nu	mber,
		To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier 1 Certi (Check only 2 Medione)	fying P cal Exa	hysicien: To the miner: On the b and man	asis of	examination ar	e, death nd/or inv	occurred at the	ne time, my opin	, date and nion, death	place, and occurred a	due to the c	ause(s) and pla	d manner as ace, and due	stated. to the cause	(s)
		To the comp	W	29b. Signature and title of cer		quer	N	X		29c. Lic	cense n	number 44	_	Í	29d. Date s	igned (Monti NBER	, Day, Year) 9, ZC	205
	(0		30 Name and address of pers	son who	M) UP	se of de	MEDIC	(Type, F	CENTE	Z.C.	be	ChAC	RP	72			
		Sta	ate	31. Date filed (Month, Day, Ye		32. F	Registra	r's Signature	Cash	20								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary	land / Depa	artment of F	lealth and	Mental Hyg	9	40344
	Physici	an	Decedent's Name (First, Middle, La	•				2. Date of Dea Month		3. Time of Death
	/Medic	al	Joan Estelle 4a. Facility Name (If not institution, giv			45 O'F. T.		ECEMBER	10, 200	5 10:25 AM
1	Examin	er	Saint Joseph		nter	40. City, 10wn, 0	TOWS		4c. County of D	timore
	Funeral Director		210 20 3007	- AM -	yrs. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1932 Ma	Birthplace (State or Foreign Country) NYLAND
	ow ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f eh	ctor	Maryland Baltim	ore	i	Vottingha	m			1 Tes 2 No
	th with the 23s or 28	Funeral Director	10e. Street and Number 4216 E. Joppa Re	oad		10f. Zip Code	21236		Og. Citizen of What	Country?
980	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow fra Madical Exertiret must be notilied at	þ	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
21215-0036	d within 72 ho giene. Ir then "netu	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Homemaken	during most of wo d)	orking	16b. Kind of Busine	·
d 2	be filed v ital Hygie d other t		17. Father's Name (First, Middle, Last	2		Tomemakel		me (First, Middle, I	Own Ho	ome.
Maryland	d is d	To Be	Edward Bilze		105 14-7		Estel	le K	ing	
N S	d 2 T is			neider (hust					r, City or Town, State	1 236
ore,	ss 1 an of Heal of Heal of Hem 2		20a. Method of Disposition	2	Ob. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
ij	mit. Page bartment o oorlant: If Injury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	St. Jose,	oh Ch. Ce	m. 12/	13/2005 1	Baltimore,	, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny Injury or ot once.		21. Signature of Funeral Service Lice	eur	9:	2. Name and Addre 105 Belai	ss of Facility Sc r Rd., B	himunek 1 altimore,	Funeral Ho , MD 21230	omes 6
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
70	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a CARDIOGE		DCK				
	Examiner		1	Due to (or as a co		LURE				
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co						
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. MASSIVE Due to (or as a co		ARY EMBO	OLISM			
68760,	te be executed ysician and ie burial-transit	calE		d. CORONARY		Y DISEAS	SE			
89	ntifical ng ph		IF FEMALE:							
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions		ot resulting in the u	inderlying cause giv	en in Part I.			to the cause of death? Probably 4\sum_Unknown
Division of Vital Records,	The law resete has being page 2 sho	Completed	DISSEMINATED	INTRAVASCULA	R COAGUL	ATION		24a. Was a autops perfor 1 Yes	ned? prior death	autopsy findings available to completion of cause of 2 No
/ita	sician: Tr certificete rector, pag	Bec	25. Was case referred to medical examiner?					ath (Check only on	(e)	
of\	Phys this al dir	10	1 ☐ Yes 2 ☑ No 27. Manner of Death		2 ER/Outpatie			Home 5 Reside	ence 6 Other (S	pecify)
O	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigated	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Wor	yat k? Yes 2∐No	28d. Describe no	ow injury occurred	
Divisi	2 2 2 2	Certification:	3 Suicide 6 Could not be determined	OB Dian of laiver	At home, farm, st pecify)	reet, factory, office		28f. Location (St City or Town		Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier 1 Certifying Pl (Check only one)	hysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tin evestigation, in my o	ne, date and plac pinion, death occ	e, and due to the courred at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1) My	29c. Licens	e number	2	9d. Date signed (Mo	
	-	1	/ Kickan	+ Lutt	Tichn	D318	326		12-10	-05
1	0		30. Name and address of person who	completed cause of death	(Item 23a) (Type,					
	Sta	ite	31. Date filed (Month, Day, Year)	32 Alegistrar's	Signatyre A		LVE TO	ا بر المتات	9 - 1 - 1 1 1 1 1	21204
	Registi		DEC 1 4 2		De Age	Bill				

				State of Maryland / Department of Health and 1- State Registrer State Of Maryland / Department of Health and Certificate of Death	Mental Hy	•	1.021 5
		Physici	an	Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Year	3. Time of Death
	1	/Medio Examin		Johnny M. Stewart, Sr. 4a. Facility Name (If not institution, give street and number) WWESSILY Speculty Hospital Battimore	Decem	4c. County of Dea	th
		Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 68 Yrs. 6. Sex 1 Months Days Hours Mi Usual Residence of Decedent		th 9. Bi	thplace (State or Foreign ountry)
5	:	ith with the Maryland 23a or 28a-f show ust be notified at	ctor	10a. State 10b. County 10c. City, Town or Location MD Baltimore Parkton			10d. Inside City Limits 1 ☐ Yes 2√∑ No
U7	:	with the a or 28 be not	Funeral Director	10e. Street and Number 928 Stablersville Road 21120		10g. Citizen of What C	ountry?
_	:	death	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No	USA 14. Race - Am	
E		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mandal Hygiens. Important if item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event. The Madical Examinar must be notified at ance.	by	1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1	arto Rican, etc.)	Specify:	white
To how	21215-0036	ithin 72 t ne. nan "nati	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	rorking	16b. Kind of Business	•
17	S.	filed with Hygiene other tha		8 Painter 17. Father's Name (First, Middle, Last) 18. Mother's N	ame (First, Middle,	Construct	ion
~	/lan	should be ind Mental i marked o umatic eve	To Be	Winfield Scott Stewart Daisy	Bell	Clark	
ewant.		d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Information Mailing Address (Street and Number or Inf			Zip Code)
00		permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once.		John M. Stewart, Jr son 16251 Falls Road, Mc 20a. Method of Disposition 1 Removed from State 20b. Place of Disposition (Name of commetery, crematory or other place)	Date Date	D 21111 20c. Location - City or	Town, State
ব্	Baltimore,	Pages Iment of I tant: If its jury or o		`4 Donation 5 Dother (Specify) Chesapeake Crematory 12/	12/2005	Beltsville	e, MD
3	Bal	Departition Depart		21. Signature of Funeral Service Licensee MO0986 MO0986 Z2. Name and Address of Facility CAFA, Stephen D. 8717 Green Pasture	Lohrmann es Drive	, PA . Towson. M	D 21286
		Inysician :		23a Part I Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	ac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
		/Medical Examiner		disease or condition resulting in death) a	ov cerv	Cl	& morg is
		LAdminer	e.	Sequentially list conditions, b. Due to (or as a consequence of):		100	400
6	760	ite be executed iysicien and ne burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.			ynowsk
	P.O. Box 68	aath certifica attending pt for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 5 Other (specify) 1 The pregnant at time of death 1 The		23d. Date of de Month	ivery Day Year
	rds, P	quires that the de in signed by the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
		ilcien: The law requires certilicate has been sign rector, page 2 should be	Completed		24a. Was autop perfor	osy prior to death?	utopsy findings available completion of cause of
	Vita	Physicien: this certific ral director,	Be		eath Check onl o		
	ion of	ng Phys Viter this uneral dii	ation: To	27. Manner of Death 1		dence 6 Other (Spenow injury occurred	cify)
	Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ro m, State)	ural Route Number,
	:	ne Hospi n 24 hour ne Funer rietely fills	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the death occurred at the death occu	ce, and due to the courred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
	,	To the I within 2. To the I complet	Me	29b. Signature and title of certifier Auchta Auch 29c. License number D 3 4 9 7		29d. Date signed (Mont	
	•	ابن			4 1	vec 9"	2005
		2+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (HARU MEHTA MD 601 SOUTH Charles St,	Kaltin.	Ora, MDZ	1230
	H	Sta Registr		31. Date filed (Month, Day, Year) 22. Registrar's Signature			

DHMH 17 Rev 1/2001

Amend item 5 per fh
Please Type or Print in Black
Amend item 5 per fh 28
Amend Item 5 per fh 28

1 - For Amend Item 23a, 25, 27, 28a In per
Registrer Print in Black Indelible Ink. Ensure All Copies Are Legible. per fl. 2851 1–12–06 vt. per fl. 2851 1–12–06 vt. per fl. 2851 1–12–06 vt. per fl. 2851 1–12–06 vt. per fl. 2851 1–12–06 vt. per fl. 2851 200 vt. per fl. 2851 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Robert J. Swec 13, 4:00 AM DEC 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Health & Rehabilitation n <u>Fllicott City</u>
If Under 1 Year | If Under 24 Hrs. | 8 Howard 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 **X**M 2□ F Hours Min. Director $218 - \frac{36}{1}$ 76 Illinois NOV 13, 1929 Usual Residence of Decedent with the Maryland 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits rel', or Items 23e or 28e-f show Examiner must be notified at 1 ☐ Yes 2 ₹No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8239 Church Lane Drive 21043 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates: Korea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White "neturel" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked o Harry Joseph Swec 2 Lena Muntain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I F. Nelline Swec, wife 8239 Church Lane Drive Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 12/13/05

21. Signature of Funeral Service Licensee George MacNabb | 22 Name and Address of Facility Department of Importent: If any injury or once. Baltimore, MD ²² Name and Address of Facility
Cremation Society of Maryland,
299 Frederick Road Baltimore. Inc 8202 MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Probable sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Backelia neumonis Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Macture sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of ding physician Box 68760. Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 2 🗆 No 1 Tyes 1 Yes Division of Vital the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending Natural 2X Accident death. A M 1 ☐ Yes 2 🛣 No investigation 1 10-10-05 Fell out of bed Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Eural Route Number City or Town, State) 8239 Church Lane Dr. þ 4 | Homicide within 24 hours at
To the Funerel D
completely filled in Ellicott City, MD at home Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3064 2 () annuly December 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi, M.D. 201 Back River Neck Rd., Suite 109 Baltimore, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32, Registrar's Signature

			State of Maryland	d / Department of H Certificate of I		tal Hygiene	005 1.031.7
	Physici	ian	1. Decedent's Name (First, Middle, Last) Marion 5 TEIN ba		2. [Dete of Deeth Month Dey	Year 3. Time of Death
, s	/Media Examir		4e Fecility Name (If not institution, give street end number)		INO LINO LINO LINO LINO LINO LINO LINO L	vember 18,	2005 11:05 PM unty of Death
7	LXXIIII	10.	Future Care Pineview		Clinton	Pri	nce George's
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 7. Age (in yrs. k	est birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. [Hours Min.	Date of Birth Month, Day, Yeer)	9. Birthplace (State or Foreign Country) Washington DC
~0.	P .		Usuel Residence of Decedent		120	,, 1,23	
	show	5		, Town or Location			10d. Inside City Limits 1 ☐ Yes 2√☐ No
	the N	ect	MD Oxon Hill 10e. Street end Number	Prince George 1	S	10g Citizer	of What Country?
	3ª or	2	1148 Kennebeck Street	701. 2.19 0000	20745	rog. Onizor	USA
	r daath	nera	11. Marital Status 12. Was Decedent Ever in U, Samed Forces?	6. 13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify In, Mexican, Puerto Rica	Yes or No- 14. n, etc.)	Race - American Indian, Black, White, etc.
Maryland 21215-0020	2 should be filed within 72 hours after death with the Maryland and Mantel Hygiana. Is marked other than "natural", or flems 23a or 28e-f show aumetic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes, Give 1 ☐ Yes, Give Yeer or Dates:	1 ☐ Yes 2 ☑ No			ecity: black
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupa	ation	16b. Kind	of Business/Industry
121	vithin han	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired		1	
d 2	Hygia Hygia ther t	ပ္	unk 17. Father's Name (First, Middle, Last)	salespers	O N 18. Mother's Name <i>(Fir</i>		tment stores unk
lan	id be ked o	To Be		dik	to moner a ream (i. ii	oi, imadio, maidon da	, and
ary	shou and M mari		19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street a	and Number or Rurel Ro	oute Number, City or To	own, Stete, Zip Code)
2	and 2 naith a 27 is		Lorraine Dancil/friend	5105 Woodland	Blvd Oxon	Hill, MD	20745
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylar Department of Haeith and Mantal Hygiena. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumetic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State	ace of Disposition (Name of metery, crematory or other place	(e)	ate 20c. Locat	ion - City or Town, State
Balt	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee Ronald S. Wade Director	22. Name and Addres State Anato Baltimore,		55 W. Balt	imore Street
			23a. Pant . Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line.			spiratory arrest,	Approximate Interval Between
	Physician /Medical Examiner						AEHNE 'S TYPE
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	cutad nd ransit	Examiner	Sequentially list conditions. b	as a consequence of):	ies all	110317 - L	AENNE 1776
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68760,	ficata ba axacutad physician and is tha burial-transit	edical	At at initiated accords	as e consequence of):			
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3,	signad d be da	Ď	Malnurishment				
Records,	raqu baan shoul	Completed	Malnurishment			24a. Was an autopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
æ	The law ta has saga 2	E			1	1 □ Yes 2 🕅	
		Be C	25. Was case referred to medical examiner?		26. Place of Deeth (Ch	7	
of V	Physiclan: this cartific iral diractor,	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ E		4 Las Nursing Home	5 ☐ Residence 6 ☐	Other (Specify)
N C	ling P Aftar t funare	Ö	1 Naturel 5 □ Pending (Month, Day Year)	28b. Time of 28c. Injury Work		Describe how injury o	ccurred
Division	Attending ir death. ector: Aftai by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury, - At hor	me, farm, street, factory, office			lumber or Rural Route Number,
á	s afta	Cert	4 Homicide determined building, etc. (Specify,			City or Town, State)	
	To the Hospital or Attending F within 24 hours aftar death. To the Funeral Director: Aftar complataly fillad in by tha funar	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death occurred at the tim on end/or investigation, in my op	ne, date and place, and c pinion, death occurred at	due to the ceuse(s) an t the time, date and pla	d manner es stated. ace, end due to the cause(s)
	To the within 2 To the I	Ž	29b. Signature and title of certifier	29c. License			igned (Month, Day, Year)
			P /our	D51.	520	11-2	29-05
			30. Name and address of person who completed cause of deeth atem Bancam Landad	W	ashingto	en DC	. 20032
	Sta Registr	100	31. Date filed (Month, Day, Year) 32. Registrer's Signar DEC 1 4 2005	dire .	0	,	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Physician	1. Decedent's Name (First, Middle, Last) Phillip Tyler	2. Date of Death Month	Day Year Year	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMUR	-E- (4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 1	8. Date of Birth Month, Day, Yes 06-08-19	9. Birth Cou	place (State or Forei ntry) VA
be notified at Director	10a. State 10b. County 10c. City, Town or Location MD BALTIMORE TURNER STATION			10d. fnside City Lim
23a or 24 uni be na	10e. Street and Number 628 N. AVONDALE ROAD 10f. Zip Code 21222	10g. (Citizen of What Cou USA	ntry?
Exemples managed by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto of the Yes, Give Year or Dates:	pecify Yes or No- b Rican, etc.)	14. Race - Ameri Bfack, White, Specify: BL	etc.
d other than "natural, of other than "natural, event, the Madical Exa	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) MECHANIC	king 16b.	Kind of Business/In	dustry
d out		ne (First, Middle, Maidle DANDRIDGE	en Sumame)	
Heelth em 27 ther tr	1 K Burial 2 Compation 3 Removal from State cemetery, crematory or other place)	Date BALTO.		7
Department of I	21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAN 1701 LAURENS ST.,			5 F.H.,I
hysicien and the burial-transit the burial-transit dical Examiner	23a. Pamf. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Last CARDIAC ARRYTHMIA Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		.)	Approximate Interval Between Onset and Deat
Ite has been signed by the attending physicien and bage 2 should be detached for use as the burial-trans.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown		23d. Date of deliv Month	ery Day Year
been signed the should be detailed be detailed.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CERCERAL INFARCTION CORONARY ARTERY		o use contribute to t 2 □ No 3 □ Pro	he cause of death pably 4 □Unkn
cate has been s page 2 should	DISCASE MYOCARDIAL INFARCTION,	24a. Was an autopsy performed?	prior to co	opsy findings avail impletion of cause
this certificate har director, page ?	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA	th (Check only one)		
rector: After by the fune	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of fnjury (Month, Day Year) 28b. Time of fnjury (Month, Day Year) 28b. Time of fnjury M 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office	28d. Describe how in 28f. Location (Street City or Town, Str	and Number or Rur	
Funer Funer Ical	29a. Certifier (Check only one) 17 Certifying Physician: To the best of my knowledge death occurred at the lime data and plans of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the causa rred at the time, date a	(e) and manner see and place, and due t	itated o the cause(s)
ro the complex	29b. Signature and title of certifier RESIDENT NEUROLOGY 29c. License number	29d. [Date signed (Month,	Day, Year)

Belinda Trotman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.PI.27.28a-f.penff. (851,1/6/06 IT State of Maryland / Department of Health and Mental Hygiene 05-08293 NJM 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year otman Delenda December. 8, 2005 /Medical 2358 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 123 S. Hilton Street Baltimore
| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) NOV, 24, (95%) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 218-64-2094 Director Yrs. Cana Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other than "naturel", or items 23s or 28s-1 showent, the Madical Examiner must be notified at 1 Yes 2 No Directo ma. 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 12 1LTON by Funeral filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: lack 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disablea 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Mental ie marked Irotman 2 lesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Heath ar Important: if item 27 te eny injury or other treu 100 man-daughter 1.73 J. HILTON 10 wand a Buttimore, 21229 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State butus mem. 05 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FredHILTON Daet , md, 2, 224 Vary timeran runeral Home grans 23a. Part 1, enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cocaine Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien and for use as the burial-transit so the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardionegaly; Cirrhosis of liver 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 A Yes 2 No page 2 s autopsy performed? 1 X Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence Nother (Specify) Scene 2 XXYes 2 □ No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 18b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 11:40 P M 2 Accident rector: by the 12/8/2005 unk 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Newsberger Russ Boute Street City or Town, State) 4 🗌 Homicide <u>ā</u> ⊆ Found at residence Baltimore, MD 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29s Conflian Medicai (Check only one)

within 24 hours a To the Funeral C completely filled

OK State Registrar

DHMH 17 Rev 1/2001

LIIYLY LI 31. Date filed (Month, Day, Year)
DEC 1 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mil

mid 111 Penn Street 2. Registrar's Signature

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

December, 9, 2005

Baltimore, Maryland 21201

			For			ent of Health and	-	_	10050
			1 - State Registrar		Certific	ate of Death	Reg.	No.	40330
	Physic		1. Decedent's Name (First, Middle, La	Timmon	5		2. Date of Death Month December	Day Year	1 100 11 11
	/Medi Examir		4a. Facility Name (If not institution, giv			ity, Town, or Location of Dea	-4	5 200. 4c. County of Dea	
		,÷ '.	5. Social Security Number 6. S	ex 7 Age (In vrs	last birthday) If Ur	Baltom ore der 1 Year If Under 24 Hi	S 9 Date of Birth	NA	the land (Change C
	Funeral Director		216-88-0805	94 20 F 38	Yrs. Mont			967	rthplace (State or Foreign country)
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location			1	10d. Inside City Limits
	the Marylar 28a-f ehow	Director	W) M	A	Baltima	ve			1 Lyes 2 □ No
	urs after death with the Maryla at', or Iteme 23a or 28a-f ehor Exerciting installed at		10e. Street and Number	Jac Grove	10f.	Zip Code	10g.	Citizen of What Co	ountry?
	er death Iteme 23	Funerai	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was De	cedent of Hispanic Origin? ((Specify Yes or No-	14. Race - Ame	
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Baltimore,	t. Pa rtmen rtant:		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Scyview 22 Name	and Address of Facility	2010,2005	Baltim	we MD
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the dea one cause on each line.	th. Do not enter the n	ode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death
100 mg	Physician /Medical		disease or condition resulting in death)	a. Jump	NOTY E	RUMA			. 1
終	Examiner		Sequentially list conditions,	· Hodgl	ans Dis	ease			1 WK
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687		edical		d					
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.O. E	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o				Month	Day Year
<u>α</u>	es that tigned by	by Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
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of <	Physic this ce	၉	1 Pres 2 No		ER/Outpatient 3	DOA Cther: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spec	cify)
ion	ding After funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	or Attendi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, Sta	and Number or Ru	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	ai Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death occurr	ad at the time, date and class	e and due to the source	/a) and	a deled
	To the Hos within 24 h To the Fun completely	ledicai	one)	niner: On the basis of examina and manner stated.	ation and/or investigati	on, in my opinion, death occ	urred at the time, date a	nd place, and due	to the cause(s)
	Vith To I	×	29b. Signature and title of certifier	1	IN	9c. License number		Date signed (Monti	
1	M	/	30. Name and address of person who	completed cause of death iter	n 23a) (Type, Print)	10100	1 0 11	recentie	V 5, 2005
\			31. Date filed (Month, Day, Year)	1953Y 22	- S. Gr	eene Stret	- Waltimo	K MD	4601
	Sta Registr			32. Registrar's Signal	H. Lon	ule			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 13, 2005 **Physician** ROSE MARY TOWNSEND 4:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson
If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. Greater Baltimore Medical Center Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 ☐ F Director 214~30~6228 75 4-4-1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28e-f show other traumatic event, the Nedical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Directo Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7842 Birmingham Avenue 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ※☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2x No Specify: 3 € Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12th grade Manager/Fabric Dept. Retail Industry Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumeth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edmond Fallon Mary Barbara Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan J. van Alphen (Daughter) 7842 Birmingham Avenue Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: It any Injury o once: Parkwood Cemetery 12~16~05 Baltimore, Maryland ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21. Signature of Funeral Service Licensee 6.3. assehr of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Procumoniae tera 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine rsicien end e burial-transit Due to (or as a consequence of): 212000 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 4 Onknown been si 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has L lirector, page 2 s 24a. Was an autopsy performed? Jouns 1 ☐ Yes 2 ☐ No 1 Yes 2 NO : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ۵ 1 Yes 2 No 1 Hipatient 2 ER/Outpatient 3 T DOA 27. Manney of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury s after de. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13/01 completed cause of death (ftem 23a) (Type, Print) POBOXYSZTIMONIUM MO 21094 30. Name and address of person v gistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 - For State Registrar	State of Marylar		artment of I		, ,	ene g. 2.005	40352
	Dhusisi	-	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Dawn Thomp	son				December		9:10 P ^M
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Dea	th	4c. County of Dea	
			5425 Highridge St	reet		Haleth			Baltimo	re
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Bir	thplace (State or Foreign ountry)
	Director		220-70-0736]M 2[X]F ∠	49 Yrs.	Months Days	TIOUTS IVE	Jan 17,	1956 Mai	ryland
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County	100 0	ity, Town or Lo					100 1-14- 05-11-5
	aryle shov	-	Maryland Baltimo		•					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	8a-1	octo		re	пале	thorpe				
	Or 2	Funeral Director	10e. Street and Number			10f. Zip Code	_	10	g. Citizen of What C	ountry?
	ath v	<u>a</u>	5425 Highridge St	reet		2122	.7		USA	
	tems	une		12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
36	s afte	by F	1 Never Married 2 Married 3 Widowed Wildowed	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2X No	Specify:		Specify: V	√hite
8	72 hours after death with the Marylend natural', or items 23a or 28a-1 show distal Examinar must be indiffed at	d b		Year or Dates:	1 10 0					
5	"neil	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wa	orking	6b. Kind of Business	/Industry
2	within	E D	Elementary/Secondary (0-12)	College (1-4or 5+)		uter Eng			Computer	
2	be filed within 72 hours after death with the Marylen Ital Hygiene. Id other than "natural", or Items 23s or 28s-f show or other than "natural", or Items 23s or 28s-f show event, the Mudical Exameline must be inviting at	e C	17. Father's Name (First, Middle, Last)		Comp	uter mig	T	me (First, Middle, Mi		
an	Mental Merkad o	CO.	Carl Francis Thom	neon				lores Coo	•	
Ë	should be and Menta marked umatic ev	2	19a. Informant's Name/Relationship (Ty)		10h 14-10-	- 8 dd (C4		ural Route Number,		7: 0 11
Maryland 21215-0036	2 6 6 7	ii i	1	•						
	of Health item 27		Carol Thompson, S		D443	HILDRIA sition (Name of	e Street	Halethor,	e Mary La Oc. Location - City or	
Ö	00==		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crer	natory`or other pla	´ I			
Baltimore,	permit. Pag Department Importent: I any Injury o		`4 □Donation 5 □ Other (Specify)			ematory			Baltimore,	Maryland
gal	Depariment Department Importment Importment Importment In Once.		21. Signature of Funeral Service Science	96	2	l. Name and Addre remation	Society	Of Maryla	and Inc.	
_	907 e a		momas Gregor/		- 4	99 Frede	rick koad	a Baltimor	e, Maryla	and 21228
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea re cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a consec	7					11 10.9
П	Examiner		Sequentially list conditions,							
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	cute	Examiner	that initiated events							
oʻ	an a urial-1		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	death certificate be executed eattending physician and of for use as the burial-transit	Cal		l						
9	ntifica ng ph as th	Med	Te ee in it							
Вох	attending p	an/A	230. Was decedent pregnant	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta		Ectopic pregnanc	v.		23d. Date of de	,
		Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of o		Other (specify)	,		Month	Day Year
P.O	at the de by the a	hys	9 ☐ Unknown	3 CUKNOWII						
	The law requires that the ite has been signed by th bage 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ë	w require been sig should b							1 XYes	2 □ No 3 □ P	robably 4 Unknown
Vital Records,	aw re	ompleted						24a. Was an	24b. Were at	utopsy findings available
Re	The lay	mo						autopsy	death?	completion of cause of
Ta		O	25. Was case referred to medical				Of Place of Do	ath (Check only one)	ZNo 1 ☐ Yes	2 No
>	Physicien: this certific ral director,	0 8	avaminar?	lospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ott		Home 5 Residen	C []Other (C	+if.1
of		H	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injui		28d. Describe how		city)
on	ding Ih. th. After funer	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ∣Yes 2 ⊡No			
Division	f or Attending after death. Director: After d in by the fune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet. factory, office		28f. Location (Stre	et and Number or Ri	ural Route Number
<u>S</u>		erti	4 Homicide	building, etc. (Speci	fy)	ooi, radiory, orned		City or Town,	State)	,
	Hospitel		29a, Certifier 1 Certifying Phys	sician: To the best of my kno	owledge death	occurred at the ti	me date and place	and due to the cau	so(e) and manner as	elated
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	(Check only 2 Medical Examinations)	ner: On the basis of examina	ation and/or inv	estigation, in my o	pinion, death occu	irred at the time, date	e and place, and due	to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	and the state of t		29c. Licens	se number	290	. Date signed (Mont	h, Day, Year)
	⊢≯⊨ŏ		Manne	M.D		1	29505	no	cember	12,2005
•	D_{Λ}		200000000000000000000000000000000000000		- 00.1 0	<u>ν</u> ,	دن دا د	100		,
	150		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	al m	Glan P	sumi	MD
			31. Date filed (Month, Day, Year)	32. Hegistrar's Signi	505	1702 17		, , , , , ,		161061
	Sta Registi		nFC 1 4 20	05	M. A.	area)				12,2005 12,2005 MD

			1 - For State Registrar	State of M	laryland		artment of H tificate of I		nd Me		jiene 1005	40353
	Physicia		Decedent's Name (First, Middle, Las	WEBSTER	. J. '	TAYLO	R			. Date of Dea Month	Day Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of		DEC.	10, 2005 4c. County of De	8:30 A ^M
			347 FAIR AVE.				WESTM				CARROL	
г	Funeral Director		5. Social Security Number 6. Se 212-05-7519	X 7. A 2 M 2 □ F	ge (In yrs. Ia 9 !		If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day		Birthplace (State or Foreign Country) RYIJAND
	Pu .		Usual Residence of Decedent 10a. State 10b. County			. Town or Lo					I I J I O PIA	
	Maryla f sho	lor	MD CARROI	L	1	STMIN						10d. Inside City Limits 1 ☐ Yes 21② No
	or 28e-	Irec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of What	
	23a c	ralD	347 FAIR AVE.				2115	57			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumatic event, The Medical Examiter must be multiled at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	? [No		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2X No		in? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Race - Al Black, W Specify: W	
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest grad			16a. Deced	lent's Usual Occupa	ation	of working		16b. Kind of Busine	
21215-0036	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT use retired)				
d 2	illed Hygie other ent, th	60	17. Father's Name (First, Middle, Last)			TR	OUBLE S			First, Middle, i	UTILITY Maiden Sumame)	CO.
Maryland	should be and Mental marked o	To B		JOHN T	. TAY	YLOR		B	BATHS	SHEBA	JONES	
Mar	id 2 sho lth and 27 Is m	1	19a. Informant's Name/Relationship (7		CON						r, City or Town, State	, ,, ,
Baltimore, I	Pages 1 and nent of Healt out: If Item 2 iry or other		WEBSTER J. TAYI 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other plac	e) 1	2/13	1/05	STMINSTE: 20c. Location - City FINKSBUR(
Baltii	permit. F Departmetimporter any injur		21. Lignature of Funeral Service Licens	see	ENT 1	22	. Name and Address	s of Facility	FLET	CHER	FUNERAL INSTER,	HOME
в			23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that cause one cause on each	d the death. line.			1				Approximate Interval Between Onset and Death
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	sit s	Iner	S puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence of):						
	al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):						
8760,	ate be executed hysician and the burial-transit	dlcal		d								
.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Date of o	delivery Day Year
S, D	The law requires that the ste has been signed by thoage 2 should be detache	by	Part II. Other significant conditions co	ntributing to death	but not resul	lting in the ur	nderlying cause give	en in Part I.			_	to the cause of death? Probably 4 Unknown
Vital Record		Completed				<u>.</u>				24a. Was a autops perform	y prior t	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			Check on on		
of	y Phys er this eral di	n: To	27. Manner of Death	1 Inpat 28a. Date of Inj	ury :	R/Outpatien 28b. Time of	t 3 DOA	4 LI Nuis			once 6 □Other (S)	pecify)
ion	Attending ir death. ector: After by the funer	atlo	1X Natural 5 ☐ Pending investigation	(Month, D	ay Year)	Injury		c? Yes 2∐No	0			
Division	i Site	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, e	itc. (Specify))	eet, factory, office			City or Towr	n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	one) 2 Medicel Exem	rsicien: To the bes iner: On the basis and manner s	of examinati	vledge, death on and/or inv	vestigation, in my or	oinion, death	place, and occurred	at the time, d	ause(s) and manner ate and place, and d	ue to the cause(s)
	To To	_	29b. Signature and title of certifier	cla			29c. License			2	9d. Date signed (Mo $12/3/2$	
1	300	2	30. Name and address of person who of THOMAS GALVIN,		2.0		Print)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	AT AT CET		
	Sta		31. Date filed (Month, Day, Year) DEC 1 4 2	32. Realist	trar's Signatu	пье	ONER AVE	. ,	MIT OT	CITNOT.	ER, MD.	4115/
	Registr	ar	DECT 44	Jej Jes	de 1	\$. S	neck					

			For State	State of Mar	-	artment of He		Mental Hy		
			Registrar 1. Decedent's Name (First, Middle, Last,		00.	Timeate of D	Calli	2. Date of De	Reg. No. 0 5	3. Finte of Death
	Physicia /Medic		JOHN H	ENRY THO	DMAS			Deler	bec 10.20	05 9:00 am
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Dea		4c. County of Dea	ath
			5. Social Security Number 6. Sec	al HOSP	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	N/A	4)-1
	Funeral Director			M 2□F	75 Yrs.	Months Days	Hours Min	(Month, Da	ay, Year)	rthplace (State or Foreign country)
	p ,		Usual Residence of Decedent					JUUNE	7,1930 VI	RGINIA
	ith the Marylar or 28a-f show e natified at	'n	MD • 10b. County		Oc. City, Town or Lo					10d. Inside City Limits
	28a-f	Director	10e. Street and Number		BALTIM	10f. Zip Code		1	10g. Citizen of What C	1. Yes 2 No
	h with	al Di	1732 N. BROAD	WAY		212	13			,
	after death w or Items 23a crimar must t	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes or No	U.S.A. 14. Race - Am Black, Wh	
36	s afte ; or it	y Ft	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, GiveX		1 ☐ Yes X☐ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	-	LACK
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show idical Exeminant be mailified at	Completed by	15. Decedent's Edu	Year or Dates: cation	16a. Dece	dent's Usual Occupat	tion		16b. Kind of Busines	
215	within 72 ene. than "na	plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	uring most of wo	orking		
	filed with Hyglene. other than	Con	7TH		SAN	ITATION			BALTIMO	RE_CITY_
and	should be filed within of Mental Hyglene. marked other than matlc event, Ire M.	o Be	17. Father's Name (First, Middle, Last) JOHN THOMAS					me (First, Middle C_ THOMP)	e, Maiden Sumame) SON	
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	1 and 2 s Health ar tom 27 is		CAROLE DENT (1	DAUGHTER)		0 DUDLEY				
Baltimore,	permit. Pages 1 au Department of Hea Important: If Item any Injury or othe once.		20a. Method of Disposition 1 □x8urial 2 □ Cremation 3 □F	lemoval from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place)	Date	20c. Location - City o	r Town, State
ţ	t. Pag rtment rtant: njury o		`4 Donation 5 ☐ Other (Specify)	10				C. 16,	2005 BALT	O, MD.
Ba	permit. Pa Departmer Important: any Injury once.		21 Signature of Funeral Service Licens	90	Č	2. Name and Address ALVIN B.	SCRUG	GS FUN	ERAL HOME	
	E 188	-	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused	e death. Do not en	$412~{ m F}$. P	RESTON , such as cardia	ST. B.	ALTO, MD.	21213 Approximate
	Physician		Immediate Cause (Final disease or condition	4000						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due t (or as a	consequence of):					
	LAdillilei	_	Sequentially list conditions,	Due to (or as a	eonsequence of):					
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o,	an an	Exa	resulting in death) Last	Due to (or as a	consequence of):					
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	ding p		IF FEMALE:	3c. If yes, outcome of	Dreggaggy					
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P.O.	t the c by the tacher	hys	9 Unknown	9□ Unknown		, , , , , , , , , , , , , , , , , ,				
	taw requires that the death certit as been signed by the attending 2 should be detached for use a	by P	Part II. Other significant conditions co				n in Part I.		tobacco use contribute	
Records,	w requir been si should	Completed by	Debridement	DY DOCK	21000	Jbitus_		1	Yes 2∐No 3∏F	Probably 4 (Monknown
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of Vital	Physician: this certific ral director,	To B	examiner?	lospital:	2 ER/Outpatie	Othor	~	ath (Check only only only only only only only only	one) idence 6 □Other (Sp	ecify)
	fing Phys I. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	(ear) 28b. Time of Injury	f 28c. Injury Work?			how injury occurred	,,
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Div	after Direction by	ertif	4 ☐ Homicide determined	building, etc.	r - At home, farm, sti (Specify)	геет, тастогу, опісе		City or To	'Street and Number or F wn, State)	sural Houte Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification:	29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge, deat	h occurred at the time	e, date and place	e, and due to the	cause(s) and manner a	s stated.
	the Hin 24 the Fi	fedic	one)	and manner state	d.			urred at the time,	date and place, and du	,
	To To	Σ	29b. Signature and title of certifier			29c. License	551	1	29d Date signed (Mon	ith, Day, Year)
7	41		30. Name and address of person who co	ampleted cause of dea	th (Item 23a) (Two	Print)	7~1		11/03	
	4		Houthoun +	91-Grain		alo maco	land (renoca	1 Hospita	\
8	THE REAL PROPERTY.	te	31. Date filed (Month, Day, Year)	32. Regitrar	s Signature				- The same	

DHMH 17 Rev 1/2001

AEM 05-08378 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item#10e,23a.27.28a-f.penff.(85).1/23/06 TT 2 State of Maryland / Department of Health and Mental Hygiene Tina Marie Utz 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 Year Month **Physician** 9:45 PM TINA MARIE UTZ December 12, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Yrs 216-02-3545 37 Director 8/11/1968 MARYLAND Usual Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits worde 1 ☐ Yes 2 ☑ No Director CARROLL WESTMINSTER MD r than "natural", or Items 23a or 28a-f the Medical Exame we must be notified 10e. Street and Numbe Ave. 10f Zip Code 10g. Citizen of What Country? death with 431 OAK BR. 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed by WHITE 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) VETERINARY ASSISTANT ANIMAL HOSPITAL 12 permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Importent: If item 27 is marked of the eny lighty or other treumatic event, page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARDING DAVID HANSON YVONNE MARIE PETRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 431 OAK AVE., WESTMINSTER, MD. 21157 YVONNE M. HANSON -MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTMINSTER CEM. 12/15/05 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E.MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fluxeline Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I are the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considuence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 ician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Dyes 2 DNo P.O. the detached Physi 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ¥ Yes 2 □ No 24a. Was an hes autopsy performed? 1 Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 3□ DOA this filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 🗌 Yes death. 12/11/05 8:22 P 2 Accident ector: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found in house 28f. Location (Street and Number or Rural Route Number, City or Town, State) 206 High St Hospital or At 24 hours efter d Funerel Direct determined 4 Homicide Carroll County, MD To the Hospital within 24 hours e 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 12, 2005 OCME Olle 1000

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State Registrar

Registrar DEC 1 4 2

31. Date filed (Month, Day, Year)

30 Name and address of person who complete

32. Registrar's Signature

of death (Item 23a) (Type, Print)

LD 111 Penn Street, Baltimore, Maryland 21201

			1 - State Registramend Item #1	State of Ma	•					ind Me	•	giene Reg. No.	005	603	56
			1. Decedent's Name (First, Middle, Last)	ya Per L	NE G85	U IZ	116/05	JH			2. Date of De	ath		3. Time	of Death
	Physici		James Phillip We:	inreich							Month Decembe	Day er 8		6:4	0 Р.м
)	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, To	wn, or L	ocation of				County of De	ath	
			5003 Gateway Te	rrace			Balt	imor	ce				Baltim	ore	
	Funeral		Social Security Number 6. Sex		e (In yrs. las	, ,	If Under 1 \	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. B	irthplace (State Country)	or Foreign
	Director		214-30-6329	M 2□F	72	Yrs.				I	Dec. 27,	1932	Ma	ryĺand	
	pu s		Usuel Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation							10d. Inside (City Limits
	aho eho	ō	,		,										s 2√2No
	288-1	ect	Maryland Baltimo: 10e. Street and Number	re	ва.	ltimo	10f. Zip Co	ode				10a. Citi	zen of What (Country?	
	with a se	Funeral Director					212					US		,.	
	leath	era	5003 Gateway Terra	12. Was Decedent I	Ever in U.S.	13. \			panic Orig	gin? (Spec	cify Yes or No lican, etc.)			nerican Indian,	
^	ther c	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 TYPes 2 1	No					, Puerto P	lican, etc.)		Black, Wh		
3	eal', o	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1953-5	5	1⊡ Yes 21∑	\$ No	Specify:				Specify: W	mire	
21215-0036	within 72 hours atter death with the Maryland ene. Then "natural", or items 23e or 28e-f ehow he Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade				dent's Usual (of workin	a	16b. Ki	nd of Busines	s/Industry	
7	thin	nple	Elementary/Secondary (0-12)	Colfege (1-4or 5	i+)	life. I	DO NOT use	retired)	•		3				
N	filed wi Hygien other th	S		4		Mec	hanica				(F) . A		ospace		
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<u>}</u>	Mer Marke Marke	ဥ				405 14-11					-		- T Ct	7'- O- d-)	
<u>a</u>	12 st h and 7 ts n treun		19a, Informant's Name/Relationship (Ty)								Route Number				7
as a	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the Marylan term 27 is marked other then "natural", or items 28 or 28s-1 show other treumstic event, the Medical Examiner must be notified at		Rosalee E. Weinre:	ich Wi	20b. Plac	e of Dispo	sition (Name	of			altimoi ate			nd 2122 or Town, State	/
Baltimore,	nt of or or or or or or or or or or or or or		1⊠Burial 2 ☐ Cremation = 3 ☐R	emoval from State			natory`or othe 11e Cei			2/13	/2005			le, Mar	vland
	it. P.	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	(A) 1 A	OLO.		2. Name and				, 2005	010	WIID VIII	10, 1141,	y zana
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ı	War to the	si.	shock, or heart failure. List only or fmmediate Cause (Finaf	ne cause on each fir	ne.	0	al							Interval Be Onset and	d Death
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В	Examiner				u 001130qu0										
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_ 		ဝိ	25. Was case referred to medical								1 Yes	2 No	1 □ Ye	es 2 No	
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Division	or Atten atter deat Director: in by the	IL Ca	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At hom	e, farm, str	reet, factory, o	office		2	8f. Location (S			Rural Route Nu	ımber,
	i ii ii e	Certification:	- I I OTHING	building, et	c. (Specify)							, 51818	<i>'</i>		
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	· C.		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	=1/5	Red -	710(1	, (-178	Jille (1 101	2107	1	
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DHMH 17 Rev 1/2001

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			3213 Fleet	Str	eet			Baltin	more						
	Funeral		5. Social Security Number	6. Se	9x 7. /	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		rth	9.	Birthpl	lace (State of	or Foreign
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Š	ra ra		Marie Woh	lfor	t /wife	<u> </u>				eet Balt	-				
ē,	s 1 and 3 Health Item 27 other tr		20a. Method of Disposition			20b. P		sition (Name of natory or other place		Date		ocation - Cit			
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	0 0 0	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Pregnant	at time of de		Ectopic pregnancy Other (specify)				Month	(Day '	Year
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	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant con	ditions co	ntributing to death	but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Did	tobacco u	se contribu	te to the	a cause of c	leath?
ğ	w raquire been sig should b		DEMENTI	<u> </u>						1 🗆	Yes 2	X No 3□] Proba	ıbly 4 ⊡l	Jnknown
Records,	aw requisite been 2 should	plet	HYPERTEN	15101	<i>\</i>					24a. Was		24b. Were	autop	sy findings	available
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	ician: certifica rector. p	0	25. Was case referred to me		-CA HON	<u> </u>			26 Place of	1 ☐ Yes		10	Yes 2		
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	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	0	0,10,		and manner	stated.	anworm	oonganon, in my op	mion, death (occurred at the time,	date and	place, and	aue to	me cause(s)
	with To t	Σ	29b. Signature and title of ce	rtifier	/			29c. License	number		29d. Dat	e signed (M	onth, D	ay, Year)	
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State of Maryland / Department of Health and Mental Hygiene] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ruth Nylin Wurtsbaugh 9:25 A M December 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year, Oct 3, 19 Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 💢 F 216-68-0053 Yrs. Director 80 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and If Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1250 Poplar Avenue 20764 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Axel Jalmar Nylin Ester Matilda Swan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Weinkam, Daughter 1250 Poplar Avenue Shady Side, Maryland 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc.: 12/12/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor ²²Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 1 Yes 2 → 100 9 Unknown 4 Pregnant at time of death 5 ☐ Other (specify) P.0. detached à signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title son who completed cause of death (Item 23a) (Type, Print) 2/00 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 17, per fly 3850 12-14-05 yt.
State of Maryland Department of Health and Mental Hygiene

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/Medical Examiner uneral rector	4	a. Facility Name (If not institution, give	AN HOSA	(In yrs. last bin	rthday)	4b. City, Town, or AAA. If Under 1 Year Months Days	TIMOR If Under 24 Hr Hours Mir	th S. 8. Date of B	4c. Co	9. Birt	
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natificant	<u> </u>	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	ountry?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:51 PM DEC YOUNG 2005 CLAYTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** NIA Amedical Center BALTIMORE BALTIMORE H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-26-711 10 M 2□F LAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumetic event, the Model Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No To Be Completed by Funerai Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ONOGH ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 ++ GRADE DRIVER KHON HEIM DISTRIBUTORS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DUNG LAVTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MCDONOGH RD. KANDALLSTOWN MD, 21133 KUTH YOUNG 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date / 1 Burial 2 □ Cremation 3 □ Removal from State 9-05 OWINGS MILLS, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
JOSEPH H
2140 N FUL BROWN JR. FUNERAL HOME 21. Sign fluit of Funeral Service Licensee BALTO, MD. 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause (Final Pnysician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUHONIA Sequentially list conditions, if any, leading to immediate cause. Enter Under vin Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 ZUnknown 24b. Were autopsy findings available prior to completion of cause of death?

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Director: After this certific
I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft To the Funerel Di completely filled in 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 17643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ION GREENE STREET BALLIMORE, MD 21201 WENTYEE TSA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			nd Item #31		<i>l</i> larylan				and M	ental Hygi	m m			
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	and *		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	d. Inside City	v Limits
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Baltimore,	f Hear fem otha	1	20a. Method of Disposition		20b. P		sition (Name of natory or other pl				c. Location -			
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Ĕ	Ing F	Į Į	1 SiNatural 5 ☐ Pending	28a. Date of In (Month, D	ay Year)	28b. Time of Injury	28c. Inju Wo M 1	ork?]Yes 2∐1		8d. Describe how	injury occur	ea		
Sic	Attanding or death. ector: After by the fune	Cat	2 Accident investigation 3 Suicide 6 Could not be	On - Disease of the		6				Of Lagation (Chro			Davida Alvert	
Division	or Attanding after death. Director: After In by the fune	Certification:	4 ☐ Homicide determined	building,	etc. (Specify	nie, rami, sm /)	et, factory, office		20	Bf. Location (Stre City or Town,	State)	er or murar	noute Numbe	91,
	pital purs prai fillad	2	29a. Certifier 1 Certifying Phys	inles: To the hos	t of my know	uladaa daath	coourred at the t	imo dete esc	delese er	and along to the con-	(-)			
	To the Hospital or Attending Physician: The is within 24 hours after death. • To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	er: On the basis and manners	of examinat	ion end/or inv	estigation, in my	opinion, deat	h occurred	d at the time, date	and place,	end due to	he cause(s)	
	o the	N N	29b. Signature and title of certifier		_		29c. Licen	se number		290	. Date signe	d (Month, D	ay, Year)	
	12)		ř)(7 7	7 7		12/2	-		
	of	1	30. Name end eddress of person who co	mpleted of so st	death /line	23a) /T	Print)	1 6 2	23		1-16	11		
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		1	For State Registrar			State o	of Mary					ealth a	and N		Reg. No.	05		362
	Physici	_	 Decedent's Name 	(First, Middle	e, Last)									2. Date of De Month	Day	Year	3. Time	of Death
10. 8	/Medic	al -	Sandra 4a, Facility Name (fi	f not inctitution	Lee			Wood	Al-	h City T	OWN OF	Location of	of Death	15	09	nty of Death	12.	12 5.11
	Examin	er	Sacred				spita	12	1	~		erla				lesan		
	Funeral		5. Social Security N		6. Sex			yrs. last birti		f Under 1		If Under Hours		8. Date of Bir	th	9. Birth	place (State	te or Foreign
	Director		220-58-0	870	1 🗆 1	W 2√ F	54	Υ	rs.	nortins	Days	Hours	IVIIII.	Mar 30	, 1951	J	(VV)	
	and .	-	Usual Residence of 10a. State	Decedent 10b. County			100	c. City, Town	or Locati	ion							10d. Inside	City Limits
	Maryll	Į.	WV	Mine	ral			Ric	lgele:	У							1 □ Y	es X∏No
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show dissil Essicilier finast be notified at	by Funeral Director	10e. Street and Nur	nb <i>e</i> r						10f. Zip (Code		-		10g. Citiz <i>e</i> n	of What Cou	ntry?	
	th with	a D	P.O. Box	405F	Robir	Drive	Э				2	6753			L	JSA		
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<u>6</u>	s t and f Health item 27 other tr		20a. Method of Disj	position				Ob. Place of	Disposition, cremato	on (Nam	e of her place	a)	-	Date	20c. Location	on - City or T	own, State	,
Ë	Pages Kent of Int: If it ury or o		1 XBurial 2 4 Donation			moval from	State	Hillcrest				1		12/12/200	5 Cumb	perland	l	MD
Baltimore,	permit. Pages 1 ar Depertment of Hea Important: If item any injury or othe once.		21. Signature of Fu	neral Service	Licensee	1.1	Car	pel	22. N	Sca	Addres rpelli Virgi	Fune	al Ho	ome, PA	land Mi	D 21502		
	DUD 3	П	23a. Part1. Enter the shock, or hea	ne disease, or	complic	ations that	caused the	eath. Do n	ot enter ti								Approxim	nate Between
	Physician		Immediate Cause disease or condition	Final	,	201010	-	ute	M	72616	dul	d in	t accio	tion			Onset a	d Death
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v _^	al-trai	Xar	that initiated events resulting in death)	•	c.	Due to	(or as a co	nsequence o	f):				- 0	20.4		,	1	7,
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Ö	tificate ng phys as the	Physician/Medical	15.55141.5		10													
Вох	eath certific attending pl for use as t	an/h	IF FEMALE: 23b. Was deceden in the past 12		23		utcome of pr	regnancy]Fetal death	3 □Ec	ctopic pre	gnancy				23d.	Date of delive	ery Day	'Y <i>e</i> ar
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Δ.	that the	Ph	Part II. Other signif	icant conditie	ons conti	ributing to d	death but no	ot resulting in	the unde	erlying ca	use give	n in Part I		23e. Did t	obacco use c	ontribute to	the cause	of death?
Records,	uires tha signed I Id be det	d by								, ,				10	Yes No	3 □ Pro	bably 4	□Unknown
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Re	The lav	E O													osy ormed?	prior to co death? 1 \(\text{Yes}	mpletion o 2∐ No	of cause of
Vital	lcien: Th certificate rector, pag	Be C	25. Was case refer	red to medica								26. Place	of Deat	1 ☐ Yes h (Check only o		1 1 1 1 1 1 1 1 1 1 1	2 🗆 140	
of V	S S	10 E	examiner? 1 ☐ Yes 2 🕽	No	Ho	spital:	Inpatient	2 ER/Out	patient	3 DO	A Othe	er: 4 □ Nu	rsing Ho	ome 5 □ Resi	dence 6 □	Other (Speci	fy)	
0	ding Phi h. After thi funeral		 Manner of Deat Natural 	5 Pendir		28a. Date (Mor	of Injury orth, Day Ye	28b. T	ime of njury		Bc. Injury Work			28d. Describe	now injury oc	curred		
Sio	Attending r death. ector: After by the funer	cat	✓2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	•	20 a Plan	a of Injune	At home for	T street	М		Yes 2□	No	28f. Location (Street and No	mbor or Pur	al Pauta A	humbas
Division	after a	Certification:	4 ☐ Homicide	determ	nined		ding, etc. (S	At home, fai Specify)	m, street,	i, ractory,	опісе			City or To		imber or Hur	ai moute N	umper,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)			er: On the I								and due to the red at the time,				e(s)
	ro the	Me	29b. Signature and	title of certifie	0 0	1				1	-	number			29d. Date sig		Dey, Yea	r)
	. , , ,		•	12	KI	L	WD				03	43(2		12/0	1/05		
	0		30. Name and addr	ess of erson	who con	npleted cau	ise of death	(Item 23a) (Type, Prir	int)						*		
_	3		Roy Ch	Sholm	, 9.	24 5	eton	pr	Cum	nbei	Klan.	d,)	nel					
*	Sta Regist		31. Date filed (Mon	15 holm th, Day, Year) C142	005	Sec.	Registrar's	Signature	perli									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:55 AM Madelvn Rizer 06 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner AlleGan YICART SACred 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Sep 17, Birthplace (State or Foreign Country) 5. Social Security Number 1913 **Funeral** 1 □ M 2 □ ¥ Months Days Hours 214-05-8356 92 Director MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show other treumatic event, the Medical Exacutuar must be notified at MD Allegany Cumberland 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 632 Fayette Street 21502 USA ітать 23а 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nurse's Aide Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theodore Andrew Wallace Mary Barbara (Geatz) Wallace 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Dunevant daughter 11 Dunkirk Road Baltimore MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State SS Peter and Paul Cemetery 12/9/2005 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 day **Physician** SEPSIS Syndron disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Fecords, P.O. Box 68760. Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) been signed by the a should be deteched t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No 1 Tyes Division of Vital the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier Workock Shin MO Dc055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

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MD

32. Registrar's Signature

WONSOCK SHIN

31. Date filed (Month, Day, Year)

Frostburg MD215

			For State Registrar	State of Maryla		artment o				giene 05	40365
	Physici /Medio Examin	an al	1. Decedent's Name (First, Middle, TALES 4a. Facility Name (If not institution, Saint, Joseph	Abdul - Ham		4b. City, Tow		o¢*	2. Date of Dea Month TOBER	Day Ye 21, 200	5 9:30 P M
	Funeral Director				s. last birthday) Yrs.	If Under 1 Y	ear If Und ays Hours		3. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	se Maryland	Director	10a. State 10b. County		City, Town or Lo	city				10.00	10d. Inside City Limits 1 Ves 2 □ No
	hours after death with the Maryland turst', or itema 23a or 28a-f show at Exp niner must be notified at	Funerai Dire	10e. Street and Number 1111 New Hope 11. Marital Status 1 ★Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?	U.S. 13.	10f. Zip Čod 21 Was Decedent If Yes, specify (202	Origin? (Spec can, Puerto R		USA 14. Race - / Black, V	American Indian, Vhite, etc.
21215-0036	"na	Completed by F	3 Widowed 4 Divorced 15. Decedent (Specify only highes) Elementary/Secondary (0-12)	If Yes, Give Year or Dates:	(Give	dent's Usual Oc kind of work do DO NOT use re	ccupation one during m atired)	-	9	16b. Kind of Busin	
Maryland 21	be filed htal Hygi hd other event, I	To Be Con	17. Father's Name (First, Middle, L SAUA Abdul-	ast) HAmid		Infan	18. Mo	ther's Name (INFAN Maiden Sumame) izzard	·†
	s 1 and 2 should f Health and Mer flem 27 is marks other traumatic		19a. Informant's Name/Relationsh AN: TRA Blizzard 20a. Method of Disposition	(mother)	Place of Dispo	NEW H	ope C		Balt	nr, City or Town, Sta	had 21202
Baltimore,	permit. Pages Department of i Important: if fit eny injury or o		1 Burial 2 Cremation 4 Donation 5 Other Sc 21. Signature 1 Final Pervice I	ecify) Ho	y Redee	matory or other mer Cem 2. Name and A	ctery			BALL MARK	Hnd Hnd
	, Physician		23a. Pant. Enter the disease, or shock or hear failure. List of Immediate Cause (Final disease or condition	complications that caused the de	ath. Do not en						Approximate Interval Between Onset and Death
,160,	/Medical Examiner obsician and period francial obsician and obsiciant and obsiciant and obsiciant and obsiciant and obsiciant and obsiciant and obs	ical Examiner	resันโting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CARDIO REDue to (or as a conse	equence of): SFIRAT equence of):		AILUR	guest Jean Marie			1H.43MIN
.O. Box 687	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1	etal death 3	⊒Ectopic pregn ⊒ Other (s <i>pecif</i>				23d. Date of Month	delivery Day Year
Ω.,	w requires that the been signed by should be detact	þ	Part II. Other significant conditio	ns contributing to death but not re	esulting in the u	underlying cause	e given in Pa	rt I.	23e. Did to	1	te to the cause of death? Probably 4 Unknown
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of VII	9 W T	To Be	examiner? 1 ☐ Yes 2 No		☐ ER/Outpatie	nt 3□DOA	Other			lence 6 Other (Specify)
Division o	Hing After fune	Medical Certification;	27. Manner of Death 1. Natural 2. Accident 3. Suicide 5. Pending investig 6. Could n	ation		М	Injury at Work?			low injury occurred	0(0
Divi	ital or Attendi urs after death ral Director: A lled in by the fi	Certif	4 Homicide determi	building, etc. (Spe	cify)				City or Tow	m, State)	r Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	ledical	one)	g Physician: To the best of my k Examiner: On the basis of exami and manner stated.	nowledge, dea nation and/or in						
•	or with con	2	29b. Signature and title of certifier	W			448219	ər		10.26.	
			30. Name and address of person	who completed cause of death (It			VF TO	WSON	MARVI	AND 2120	
	St. Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	6 -0					

DHMH 17 Rev 1/2001

Registrar

DEC 0 1 2005 ▶

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Maxine Brewton December 3, 2005 7:30 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 17 East Pennington Street 0akland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🖾 F Yrs. Sept. 26,1923 204-16-5443 82 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County 1 Yes 2 No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 East Pennington Street 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Stiffler Carlton Florence Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joy B. Haines/Daughter 25 E. Pennington Street, Oakland, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/7/05 4 ☐ Donation 5 ☐ Other (Specify) Oakland, Maryland Oakland Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 32 S. Second St. Oakland, Md. 21550 Stewart Funeral Home Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) years a Renal Cell Carcinoma metastatic to lung and liver Due to (or as a consequence of):

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, physician Be Completed by Physician/Medical for the detached ģ signed t page 2 s ۵ .his after death.

Physician

/Medical

Examiner

Direct

Funeral

Completed by

Be

2

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Madical Examiner must be motified at

al Hygiene.

and Mental I

item 27 i

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Department of important: If any injury or once.

Physician

/Medical

Examiner

Pages 1 and 2 should be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ctopic pregnancy tther (specify)		23d. Date of delivery Month Day	Year
ed by Ph	Part II. Other significant conditions c	ontributing to death but not resulting in the und	erlying cause given in Part I.		use contribute to the cause	of death? Unknown
Complet				24a. Was an autopsy performed?	24b. Were autopsy find prior to completion death?	ngs available of cause of
Be (25. Was case referred to medical		26. Place of Death	(Check only one)		
To B	examiner?	Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Hor	me Residence	6 ☐Other (Specify)	
	27. Manner of Death Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route e)	Number,
Medical Certification:		ysician: To the best of my knowledge, death o niner: On the basis of examination and/or inves and manner stated.				se(s)
Me	29b. Signature and title of certifier	July 1	29c. License number		te signed <i>(Month, Day, Yei</i> 2/5/2005	ar)

Fourth St., Oakland, Md. 21550

DHMH 17 Rev 1/2001

State

Registrar

filled in by

within 2. To the f

311 N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

A. Walsh

6 2005

Charles

31. Date filed (Month, Day, Year)

DEC -

		-	For State Registrar	State of Maryla	and / Depa	artment of F	Health an <i>Death</i>	nd Mental H	ygiene	05	40369
G.F		Q-*	Decedent's Name (First, Middle, Last)		-			2. Date of I	Death Day	Year	3. Time of Death
	Physici		John Lockard Barn	es. Sr.					mber 27		10:45 ^p M
).	/Medic Examin		4a. Facility Name (If not institution, give :			4b. City, Town, o	or Location of [unty of Death	
• 0	LAdimii		Holy Cross Hospit	al		Silver	Spring		M	ontgom	erv
	Funeral		Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of 8		9. Birth	place (State or Foreign ntry)
)ja	Director		216-22-8915	M 2□F	78 Yrs.				5, 1927		yland
	p ,		Usual Residence of Decedent 10a, State 10b, County	10c	City, Town or Lo	ocation					10d. Inside City Limits
	anyla ehov	2									1 ☐ Yes 2√☐ No
	88a-1	Directo	Maryland Montgon	iery	Silver S	10f. Zip Code			10g Citizen	of What Cou	intry?
	with t		Toe. Street and Inditioe			Tot. Zip Godo					,
	sath sa 23	Funeral	902 West Nolcrest	Drive 12. Was Decedent Ever i	n U.S. 13.	20903 Was Decedent of	Hispanic Origin	n? (Specify Yes or	US:	A Race - Ameri	can Indian,
	iten d	Š	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No	:	If Yes, specify Cub	an, Mexican, i	Puèrto Rican, etc.)		Black, White	
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5-0036	2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occu	pation	of working	16b. Kind	of Business/Ir	ndustry
215	within 72 ene. then "nal	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	,g	Inter	rnal Re	evenue
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nd	oe filed vial Hygie d other i	Be	17. Father's Name (First, Middle, Last)					s Name (First, Midd		mame)	
aryland	should be and Mental marked o	ဥ	Maurice Lockard E			4.11.		tha Mae N		Ctata 7	in Confel
Jar	le sh is m		19a. Informant's Name/Relationship (T) John L. Barnes, J	_				or Rural Route Nur.			
6	1 and Health em 27 ther tr		20a. Method of Disposition		Db. Place of Disp		v Grove	Road, 01		ion - City or T	
ŏ	Pages nent of h ant: if its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F			matory or other pla int Cemet		December 2		- - -	Marriand
Baltimore,	rtmer rtant njury		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens					2005	-		Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23s or 28s-1 show emportant: if item 27 is marked other then "natural; or items 23s or 28s-1 show employ or other traumatic event, the Madical Examination and the notified at ADGS.			0				ins Funer			
	IS 12"		23a. Part1. Enter the disease, or comp	ications that caused the	death. Do not en	00 Unive	rsity l	Blvd, W, ardiac or respirator	Silver arrest,	Spring	MD 20901
	*		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cor		ic Leuke	mia				
	Examiner			Sensis	1304401100 017.						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):						
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	Thrombocy							
ó	en ar	EX	resulting in death) Last	Due to (or as a cor	nsequence of):						
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9	ng pt	Med	IF FEMALE:							1.	
Вох	eath certifi attending I for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pro 1 Live birth 2	Fetal death 3	□Ectopic pregnan	су		230	 Date of deli- Month 	very Day Year
	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	of death 5	Other (specify)					
P.0	iaw requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions co	ntributing to death but no	t resulting in the	underlying cause g	iven in Part I.	23e. D	id tobacco use	contribute to	the cause of death?
ds,	ries tha signed d be det	l by				, , ,		1-	□Yes 2□N	No 3□Pro	bably 4 📆 nknown
Records,	v require been sig should b	ompieted						24a. W	Mas an 2	24h Were au	tonsy findings available
3ec	0 4 6	E I						aı	utopsy erformed?	death?	topsy findings available ompletion of cause of
a	ician: The certificate ha	O				-	OC Pleas	1 Tye		1 ∐ Yes	2 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	2 ER/Outpatie	ent 3 DOA	thor	of Death <i>Check on</i> sing Home 5□R		Other (Spec	ntv)
of	Physic this stal di	-	27. Manner of Death	28a. Date of Injury	28b. Time				oe how injury o		***/
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ā	ator s afte ni Dir	Certification:	4 - Homeda	building, etc. (3)	pacity)						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29a. Certifier Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my	y knowledge, dea mination and/or i	th occurred at the	time, date and	I place, and due to the occurred at the tin	the cause(s) an	nd manner as ace, and due	stated. to the cause(s)
	To the Hi within 24 To the Fi complete	Medicai	one)	and manner stated.							
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	(0		30. Name and address of person who o		(Item 23a) (Type	819 G	5) L. T.	HERS BI	124-	UD :	20883.
			AHMED NAWA 31. Date filed (Month, Ray, Year)	32. Registrar's			7 111	, UP DO			-000
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	Physicia /Medic		Decedent's Name (First, Middle, Las PHILLIP P. BECK	n) 						2. Date of Deat Month DECEMBE	$\mathbb{R}^{\stackrel{Day}{1}}, 2$	005	3. Time of Death 2:06A. M
	Examin		4a. Facility Name (If not institution, give HOLY CROSS HOSPIT					Town, or L VER S	ocation of Death. PRING		4c. Count		
	Funeral		Social Security Number 6. Security Number	7. Ag	e (In yrs. la	st birth	1111		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
	Director	-	213-96-4221 Usual Residence of Decedent	ØM 2□F	39	Y	rs.			Oct. 15,	1966	Rockv	ille, MD
	uryland show		10a. State 10b. County		10c. City	, Town	or Location					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Ma 28a-f	Director	MD Montgome	ery	Silv	/er	Spring 10f. Zi	Code		1	0g. Citizen of	What Cour	
	3e or		11802 Huggins Dr	ive				0902		1	nited	State	S
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Insurportant: If the Z7 is marked other then "natural; or tiems 23s or 28s-f show enyportant: If the Z7 is marked other then "natural; or tiems 27 is marked other then "natural be notified at once."	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	Ever in U.S No	S	13. Was Dece	dent of His cify Cuban	panic Origin? (Si , Mexican, Puerto Specify:	pecify Yes or No-	14. Ra Bla	ce - Amendack, White,	an Indi <i>a</i> n, etc.
9	72 hou	ted	15. Decedent's Ed	ucation		16a. l	Decedent's Usu Give kind of w	al Occupat	ion iring most of work	kına	16b. Kind of E	Business/In	dustry
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lan∫	2 sho and 1 le ma		19a. Informant's Name/Relationship (7							ral Route Number	60 1393		
e,	1 and Health Pm 27		Julie Beck, Spous 20a. Method of Disposition	se	20b. Pl		.802 Hui Disposition (Na r, crematory or			Silver S	pring, 20c. Location		
nor	ages it: If it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		n Mem.		1	1-2005	Rockvi	11e. i	MD
Baltimore, Maryland	mit. F pertme portan y Injur		21. Signature of Funeral Service Licen	_	^								Home, Inc.
<u>~</u>	Depe Impo eny I		23a. Part 1. Enter the disease or domi	Womel	9		1			Ave Sil		ring	MD 20904 Approximate
	/Medical cien and Examiner	Examiner	shock, or heart failure. List-ody Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	rphone lerot a consequ	ience o	f): f):	tion (complica lar Dise	ting Hyp ase	ertens	ive	Interval Between Onset and Death
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P.O. Box 6	death certif e attending ad for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death	3 ☐ Ectopic 5 ☐ Other (s					ate of deliver	ery Day Year
	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of Renal disease	ontributing to death b	out not resu	ulting in	the underlying	cause give	n in Part I.	1	bacco use cor es 2 □ No	ntribute to t 3 ☐ Prot	he cause of death?
Il Records,	The ate ha	Completed								24a. Was a autop: perfor 1 Nes	sy	prior to co	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:	0.000	ED/O	tit 00 5	Othe	-	ath <i>Check</i> only or lome 5 Resid		thas (Casa)	F.1
o	ding Ph h. After th funeral	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ury av Year)	28b. T	iurv	28c. Injury Work	at	28d. Describe h		ırred	unk
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	1:4. me, fai /)	m, street, facto			28f. Location (S City or Tow Silver	treet and Num n, State) 11 Spring	802 FH • MD	uggins Dr.,
	e Hospit 124 hours Funera	edlcal (ysicien: To the best niner: On the basis of and manner st	of examinat					, and due to the o	ause(s) and n	nanner as s	
	To th withir To th comp	Me	29b. Signature and title of certifier	a 1/1		ß	2	9c. License	number	-	29d. Date sign	ed (Month,	Day, Year)
	ν		> Courde H	Meldi	- W-	d		0.C.	M.E.	I	ECEMBE	R 2,	2005
_			30. Name and address of person who	retur	vol		111	PENN	STREET	BALTIMOR	RE MARY	LAND	21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 9 20	32 Regist	rar's Signa	ture	harles						

State of Maryland / Department of Health and Mental Hygiepe 15 Certificate of Death Req. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 2, 2005 Metcalf Burke 2:15рм Benjamin **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown, Washington Avalon Manor Health Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 18, 1917 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F 88 Yrs. 705-14-0248 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "naturel; or Items 23e or 28a-f show other treumatic event, it a Madical Executes must be reciliad at 1 ☐ Yes 🏋 ☐ No Washington Hagerstown MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 14014 Marsh Pike death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) railroad Elementary/Secondary (0-12) College (1-4or 5+) carman permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If liem 27 is marked other the any Injury or other treumsting. 5th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel H. Burke Clara Lucretia Metcalf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Loyalton-Apt247 20009 Rosebank Way 19a. Informant's Name/Relationship (Type, Print) wife Thelma F.Burke 20b. Place of Disposition (Name of competery, crematory or other place) Delc. 6, 2005

Hagerstown, Maryland 21740

20c. Location - City or Town, State
Hagerstown - MT 20a. Method of Disposition Hagerstown, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hu Physician berter live /Medical Due to (or as a consequence of): Examiner Ener Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐ Pregnant at time of death 5 Other (specify) P.O. P cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 № known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel L To the Hospitel t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Ct. Hagerstown, MD 21742 Klahid Waseem 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 0 5 2005** Registrar

ORIGINAL

			ricasc	State of Ma					Mental Hyg	•	iic.
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	Dhysini	on.	Decedent's Name (First, Middle, Lass Torrow	f.	Blake	Sr			2. Date of Dea Month	nth Day	3. Time of Death
1	Physici /Medic		Leroy		DIARC				Novemb	er 12,	2005 4:35P ^M
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	Funeral		5. Social Security Number 6. Se		e (In yrs. last bi	M	Under 1 Year onths Days	If Under 24 H		Year)	Birthplace (State or Foreign Country)
	Director		213 10 2731	ØM 2□F	83	Yrs.	Onurs Days	110013	June 2	3,1922	Maryland
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location	on				10d. Inside City Limits
	Mary a-f eh	tor	Maryland Calv	ert		Lu	sby				1 ☐ Yes 2 ☐ XNo
	or 28	Director	10e. Street and Number		_	1	10f. Zip Code			10g. Citizen of WI	nat Country?
	s 23a	rai	12110 Rousby			12 Was	206		Specify Ves or No-	USA 14 Bace	- American Indian,
' 0	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 XYes 2 1	No 1943-	• t			(Specify Ye <i>s o</i> r No- arto Rican, etc.)		, White, etc.
036	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1 📗	Yes 2 No	Specify:		Specify:	Black
15-0	d within 72 hours after death with the Maryland jiene. It then "naturel", or Items 23a or 28a-f ehow It is Madical Exportment out by melliked at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	(Give kind	's Usual Occupa d of work done d NOT use retired)	ition Juring most of w	orking	16b. Kind of Bus Federa	·
12	withir ene. then	duic	Elementary/Secondary (0-12)	College (1-4or 5	5+)		Engine			Govern	
DE 2	int,	Be C	17. Father's Name (First, Middle, Last)	D1 1					ame (First, Middle,	Maiden Sumame)
ylar	should be ind Mental marked c	To	William Henr					Eliza		aisey	Dorsey
Maryland 21215-0036	12 sho h and 7 Is m traum	13	19a. Informant's Name/Relationship (7) Ruth Blake/wif						Rural Route Numbe Rd. Lu		
e,	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition		20b. Place of	of Dispositio	on (Name of		Date		City or Town, State
OE	Page ient o nt: If ry or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State)	Easte	ern U	ory or other place MC Cem	. 11/	19/05	Lusby,	MD
Baltimore,	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Licen	see	,	22. Na	ame and Addres	s of Facility	ewell F	uņeral	Home MD20676
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Вох	attend for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		opic pregnancy her (specify)			23d. Date Mont	of delivery h Day Year
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al		e Co	25. Was case referred to medical	strated	rne	y ren	noney	26 Place of D		2 No 1	Yes 2 No
<u> </u>	Physicien: r this certific ral director,	0 8	examiner? 1 \(\text{Yes} \) 2 \(\text{No.} \)	Hospital: 1 Inpatie	ent 2 ER/O	outpatient 3	3□ DOA Othe		1	ence 6 Other	(Specify)
n of	Te e	on: T	27. Mann of Death 1	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work	:?	28d. Describe h	ow injury occurre	d
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	ne Hospital or Attendi n 24 hours after death. ne Funerel Director: A pletely filled in by the fu		29a. Certifier 1 rertifying Ph	ysicien: To the best	of my knowledg	ge, death oc	curred at the tim	e, date and pla	ce, and due to the c	ause(s) and man	ner as stated. Indicate to the cause(s)
	To the Hospital or Atti within 24 hours after de To the Funerel Directi completely filled in by ti	Medical	one) 29b. Signature and title of certifier	and manner str			29c. License			29d. Date signed	(Month, Dav. Year)
	To To		A T COLUMN	unst.	7 L	` -	D	194	27	11-11	4-2005
			30. Name and address of person who	completed cause of o	leath (Item 23a)) (Type, Prin	nt)	1 1 1	/		
(+1		Anwar T. Munsh		1.6:		Prin	ce Fre	derick,	MD 206	78
	Sta Registr		31. Date filed (Month, Day, Year)	4 2005	ays Signature	K.	Coste				
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			For State Registrar	State o	of Marylai	nd / Depa <i>Cei</i>	irtment <i>tificate</i>	of H	ealth ar D <i>eath</i>	nd Mental H	ygiene Reg. No.	005	L	0373
× v	* * *		1. Decedent's Name (First, Middle, Las	st)						2. Date of I	Death Day	. Ye	ear	3. Time of Death
E	Physici /Medic		Virgie Mae Carey							Noven	der 2	7 2	035	1120 PM
	Examin	er	4a. Facility Name (If not institution, give						Location of		4c.	County of I		
- 7			Washington County 5. Social Security Number 6. S			. last birthday)	If Under 1		rstown		Rinth	Wash:		
30	Funeral Director			☐ M 2 ☐ F	7. 79	Yrs.		Days		Min. 8. Date of 8 (Month, 1) May 3	Day, Year)	26 M	Count	ace (State or Foreign ry) and
40			Usual Residence of Decedent							Tray 5	, .,			
	how		10a, State 10b. County		10c. C	ity, Town or Lo	cation						10	Od. Inside City Limits
	Be-f	cto	Maryland Washing	ton		Hager					-			1XXYes 2 □ No
	vith th	Oire	10e. Street and Number				10f. Zip (zen of Wha		-
	a 23s	Frai	12 South Walnut S		edent Ever in I	12 12 1	217		enanic Origi	n? (Specify Yes or I		nited 14. Race · .		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Itama 23a or 28e-f ehow any injury or other traumatic event, the Medical Evantra must be notified at ADES.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed For I Tyes, Gi	orces? 2 — No ive		Yes, specif	fy Cuba	Specify:	Puerto Rican, etc.)			White, e	etc.
0-10	2 ho	ted	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual	Occupa	ation during most o	of working	16b. Ki	nd of Busin	ess/Ind	ustry
215	thin 7	Completed	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use	e retired)	or working				
21	ygien ygien yer th	Sol	8			Cust	odial	Eng		- Na (First Afid-			Gove	rnment
and	tal H	Be	17. Father's Name (First, Middle, Last) Earl M. Reynolds							s Name <i>(First, Midd</i> n L. Haine		Surname)		
ž	d Mer d Mer mark matic	ဥ	19a. Informant's Name/Relationship (Tyne Print)		19b Mailir	a Address /	(Street a		or Rural Route Nun		r Town Sta	te Zin	Code)
<u>⊠</u>	ith an	6	Bonita Kolb / Dau							erstown,			. O, _,p	3 000
ē,	s 1 ar		20a. Method of Disposition	licei	20b.	Place of Dispo	sition (Name	e of		Date	20c, Lo	cation - Cit	y or Tov	wn, State
OE.	Page: ent ol nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		- 1	sthaven	-		,,,,,	cember 2, 2005		erick	_ M	aryland
Baltimore,	Departm Departm Importa any inju		21. Signature of Funeral Service Licer	ISBB	, rec					1 Service				
<u>m</u>	88 5 6		1///	7		95	01 Ca	toct	tin Mt	n. Hwy. F	reder			
	Physician /Medical		23a. Part: Enter the disease, or com shock, or heart tanure. List on Immediate Cause (Final disease or condition resulting in death)	a. Re	Shiva	ath. Do not ent	er the mode	of dying	g, such as ca	ardiac or respiratory	arrest,			Approximate Interval Between Onset and Death
	Examiner				(or as a conse	. 0	110	+		1 0			-	150
		Je.	Sequentially list conditions, if any, leading to immediate		(or as a conse		Hec	ΙΥΙ	1,50	c x vyq				0 ×
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Pa	enmon	504								20
Ő,	cate be executed obysician and the burial-transit	EX	resulting in death) Last	Due to	(or as a conse	quence of):								
8760,	ate b	dical	•	d								-		
). Box 6	sath certifi ettending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregi birth 2 Fel nant at time of	tal death 3	Ectopic pre				-	23d. Date o Month		ry Day Year
P.0	₽ > 3		Part II. Other significant conditions of	ontributina to c	leath but not re	sulting in the u	ndertving ca	use aive	en in Part I.	23e. Di	d tobacco u	ise contribu	ite to the	e cause of death?
ds,	signe d be	d by	•	•		· ·	, ,	•		10	Yes 2	□No 3[☐ Proba	ably 4 DUnknown
Records,	The law requires that ate has been signed b pege 2 should be deta	Completed						-		pe	topsy rformed?	prio	r to com th?	osy findings available inpletion of cause of
Vital	ician: Th certificate rector, peg	a	25. Was case referred to medical				11777 - A	en in Alle	26. Place o	1 ☐ Yes of Death (Check on)		,,,	Yes :	2 NO
<u> </u>	5 5 £	To B	examiner? 1 ☐ Yes 250€No	Hospital:	Inpatient 2	☐ ER/Outpatier	t 3 DO	Othe	er: 4 🗆 Nurs	sing Home 5 🗆 Re	sidence	6 Other (Specify)
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Dite (Mor	of Injury oth, Day Year)	28b. Time of Injury	28	c. Injury Work		28d. Describ				
sio	Attending F r death. ector: After by the funera	cati	2 Accident investigatio				М		Yes 2 □ N					
Division	l or Attendater deatl	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Plac	e of Injury - At ling, etc. <i>(Spe</i> c	home, farm, str cify)	eet, factory,	office			(Street an Town, State		ər Rurai	Route Number,
_	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	edicai C		niner: On the I						place, and due to the control occurred at the time				
	To the within 2 To the Complet	Me	29b. Signature and title of certifier				29c.	License	number		29d. Dat	e signed (A	Aonth, E	Day, Year)
	. •			2 6-					052	323		11/22	3/4	_
	5		30. Name and address of person who	112	600	al C	unt	_	/try	Md	217	and the second of the second o	,	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0	2005	Regisfar's Sign	nature	bare	2	7					

		ľ	1 _ State	State of Maryla		artment of H		nd Mental I	Hygien	3 2 3 6 3 3 7 7	4037	7 4
			Registrar 1. Decedent's Name (First, Middle, Last)	. 1				2. Date of Month			3. Time of D	eath
	Physicia /Medic		Thomas J.	Curley	,71,			No	10,24	1, 200	5 5:00	Рм
	Examin		4a. Facility Name (If not institution, give st 11 Silverwood Circ			4b. City, Town, or Annapol		Death	40	: County of Dea Anne A		
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	II Under 24	Hrs. 8. Date of	Birth	9 Bi	rthplace (State or i	Foreign
	Funeral Director			M 2□F 8	2 Yrs.	Months Days	Hours	Dec.	Day, Year 12, 1	922 Ma	ssachuse	tts_
	D .		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation		-			10d. Inside City	Limits
	Maryla f ehor	ō	Maryland Anne Arun		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		apolis	;			1 X Yes 2	
	r 28e-	rect	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	Country?	
	deeth with the Maryland ms 23a or 28s-f show ir must be notified at	by Funeral Director	11 Silverwood Circ	ele, Apt. 8			1403			U.S.		
	tems	unei	Tr. Markar States	 Was Decedent Ever in Armed Forces? 1 XYes 2 No 	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin n, Mexican, I	n? (Specify Yes o Puerto Rican, etc.	No-	14. Race - Am Black, Wh		
0000	urs aft		1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW	II	1 ☐ Yes 2 🔀 No	Specify:			Specify: W	hite	
֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֝֝֝	72 ho	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	furing most o	of working	16b. l	Kind of Busines	s/Industry	
7	within ine. Ihan *	mp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retired Judge)		Co	unty Go	vernment	
7	Hygia Hygia other	ပိ	17. Father's Name (First, Middle, Last)			Juage	18. Mother's	s Name (First, Mic			VCITARCITE	
yland	uld be Aental rked c	To Be	Thomas Joseph Curl	ey, Sr.			Ann	e Lundy				
Mary	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depermitmant of Health and Mental Hygiane. Deperment of Health and Mental Hygiane. Enough injury or other treumatic event, the Medical Enaminar must be notified at Once.	·	19a. Informant's Name/Relationship (Typ Caryn Walaski/dau		1	ng Address (Street ardamon D		or Rural Route Nu Edgewate			Zip Code) 21037	
ย์	Healt Healt tem 2		20a. Method of Disposition	20b	. Place of Dispo	osition (Name of matory or other place	!	Date		ocation - City o	r Town, State	
E	Pages nant of nat: If I		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	Mem. Gar	1	1/30/200	5 Dav	idsonvi	lle, Mar	yland
Бапппо	Depermit. Depertmine imports any inju		21. Signature of Funeral Service License		2:	2. Name and Addres	s of Facility	John M.	Taylo	r Funer	al Home	
	KOE S O		23a. Part1. Enter the disease, or complic	, accept		47 Duke o				nnapoli	S, MD 214 Approximate	401
			shock, or heert failure. List only one	e cause on each line.					, y arrost,		Onset and De	eath
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):	lung	Caric	er			6 Wee	2/05
ı	Examiner		Sequentially list conditions, b.						-			
ī	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a cons	equence of):							
<u>.</u>	execu in and ial-tra	Exar	that initiated events c. resulting in death) Last	Due to (or as a cons	equence of):					*		
2/00/2	certificate be executed iding physicien and ise as the burial-transit	icai	C d.									
o XO	eath certific: attending pl for use as t	/Med	IF FEMALE:	ic. If yes, outcome of preg	nancy					23d. Date of de	olivon	
0	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o	etel death 3	□Ectopic pregnancy □ Other (specify)				Month	Day Ye	ar
	at the de by the tached	Physician/Med	9 Unknown	9□ Unknown								
ds,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions cont	ributing to death but not r	esulting in the u	inderlying cause givi	en in Part I.		1		to the cause of dea Probably 4 \(\square\)Un	
	v requ been should	letec						24a. \	Vas an	24b. Were a	autopsy findings av	/ailable
Ē	0 5 0	Completed						a	utopsy erformed? es 22N	prior to death?	completion of cau	ise of
	yslcien: This certificate director, pag	BeC	25. Was case referred to medical examiner?					of Death (Check of				
5	hys this	ဂ္	1 □ Yes 2 □ No		ER/Outpatie		4 LINUIS	ing Home 5 F		6 □Other (Sp	ecify)	
	ding h. Afte funa	tion	27. Manner of Death` 1	28a. Date of Injury (Month, Day Year)	Injury	Wor	k?` Yes 2∐No		ibe now inju	ary occurred		
Vision	Attending ar death. ractor: After by the funa	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	home, farm, st	reet, lactory, office		28I. Location	on (Street a	nd Number or F	Rural Route Numbe	9r,
5	To the Hospital or Attenwithin 24 hours after deet To the Funeral Director: complately filled in by the	O				th appropriate the time	no doto and	place and due to	the agues/	-\	a catatod	
	To the Hospital within 24 hours a To the Funeral Complataly filled in	dicai	29a. Certifier 1 X Cartifying Phys. (Check only 2 Madical Examin one)	ician: To the best of my le er: On the basis of exam and manner stated.	ination and/or in	in occurred at the till evestigation, in my o	pinion, death	occurred at the ti	me, date ar	nd place, and du	ue to the cause(s)	
	To the within 2 To the complat	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	ate signed (Mor	nth, Day, Year)	
•			1. Cemn				591	73	<u> </u>	11- Z8	5-05	
			30. Name and address of person who con	mpleted cause of death (I	1900 (Type)	estate	Red;	#300, 8	Inna	plus	3-05 , MD2	140
j	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature &	sall s						

			1 - For State Registrar	State of Ma	aryland / I		rtment of ificate of			lental Hy	gien Reg. N) A A E	40375
			Decedent's Name (First, Middle, Last)						2. Date of De		av Ve	3. Time of Death
	Physici /Medic		Alice Armes Court	ney						11/23/	/20Ŏ	5	12:27 PM
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location	of Death			c. County of I	
			Laurel Regional Ho				Laurel	I Milloda	- 04 () - 0		1		Georges
	Funeral Director		3/9-38-/869	7. Ag	e (In yrs. last bi	Yrs.	Months Days		Min.	8. Date of Bi (Month, Pi 02/28/	rth ay, Year L928	r) 9.	Birthplace (State or Foreign Country) irginia
	pu ≱		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation						10d. Inside City Limits
	Aaryle r sho	ъ											1X Yes 2 □ No
	28a-	ect	Maryland Prince G	eorges	Bowie		10f. Zip Code				10g. C	itizen of Wha	t Country?
	with 3a or	۵	3200 Moylan Drive				20715				USA		
	ms 2:	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	as Decedent of	Hispanic O	rigin? (Sp	ecify Yes or N		14. Race - /	American Indian,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Medicul Evandrat must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		Yes, specify Cu □ Yes 2【X] No			rican, etc.)		Specify: W	White, etc. hite
21215-0036	2 hou	ted	15. Decedent's Ed	ucation	168	a. Decede	ent's Usual Occu	pation	nt of work	ina	16b.	Kind of Busin	
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21	giene giene er tha	Com	Editionally (6 12)	2		Secr	etary				F.	B.I.	
	al Hy I other	Be (17. Father's Name (First, Middle, Last)					18. Moth	er's Nam	e (First, Middle	e, Maide	n Sumame)	
/lai	Ment Ment arked arice	Tol	Wicker Armes						Gib				
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (7			-	Address (Stree				_		te, Zip Code)
	and ealth m 27		Marilyn R. Courtn	ey/ Daugh			Moylan l			D-1-			y as Town State
Baltimore,	Pages 1 lent of H nt: If ite ry or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Meth	odis	ition (Name of atony of other of K United t Churc	ace)	11/3	0/2005	Mit	chellv	ille, MD eral Home
Balti	permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 Is mar any injury or other traumat once.		21. Signature of Suneral Service Licen	See		22.	Name and Add	ress of Faci	lity Rob	ert E.	Eva	ns Fun	eral Home
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do							207	Approximate Interval Between
	Dhusisian		shock, or heart failure. List only of Immediate Cause (Final			t mi o	ol Aoti						Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Pulsele:	a consequence		al ACCI	VILY					
	Examiner			Myocard			ion						
Ш		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):							
	cuted	Examiner	that initiated events	c. Congest			ailure						
0,	e exe ian a urial-1	EX	resulting in death) Last	,	a consequence								
8760,	cate be executed physician and the burial-transit	dicai	•	d. Coronar	y Arter	y Di	sease						
Box 6	auth certiff attending for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 [X]No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal deat		Ectopic pregnan Other (specify)	су				23d. Date of Month	f delivery Day Year
P.0	d by	Phy	Part II. Other significant conditions of	ontributing to death h	out not resulting	in the un	deriving cause o	iven in Part	1.	23e. Did	tobacco	use contribu	te to the cause of death?
JS,	w requires that the debeen signed by the should be detached	by	Hypoxia, Pneumoni	-			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10	Yes :	2 □ No 3X	Probably 4 □Unknown
0.00	requ	etec								24a. Wa		24h Wor	re autopsy findings available
Records,	e lav has je 2	Completed	Respiratory Insuf	ficiency						auto	opsy formed?	prio dea	r to completion of cause of
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						ce of Deat	h (Check only	оле)		
of V	SI SI	2	1 ☐ Yes 2 💢 No	Hospital: 1X Inpati			3 DOA		lursing Ho	ome 5 Res			Specify)
lon c	ling After fune	ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da		. Time of Injury	28c. In W	uryat ork? ∐Yes 2.[□No	28d. Describe	how inj	ury occurred	
Division	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, tc. (Specify)	farm, stre	et, factory, offic	9		28f. Location City or To	(Street a	and Number o	or Rural Route Number,
	To the Hospital or At within 24 hours after or To tha Funeral Direct completely filled in by	edical (29a. Certifier 1 To Certifying Ph (Check only 2 Medical Exan	ysician: To the best niner: On the basis of and manner st	of examination a	ge, death and/or inv	occurred at the estigation, in my	time, date a opinion, de	and place, eath occur	and due to the red at the time	e cause(, date a	s) and manne nd place, and	er as stated. due to the cause(s)
	Fo th within Fo tha	Me	29b. Signature and title of certifier	10			29c. Lice	nse number			29d. D	ate signed (A	Month, Day, Year)
	0		1	tel			D005	9228			11/	23/200	15
			30. Name and address of person who				Print)					-,	
			E. Pasmanik, MD	14201 Lau	rel Par	k Dr	ive, #2	26 La	ure1,	MD 20	707		
	St	ate	31. Date filed (Month, Day, Year)	2005 32. Registi	rar's Signature	k Z	Costs!						

		_	1 - For State Registrar	State of M	larylan		artmen rtificat			nd Mental I	lygie:	1000	403	16
	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Month		Day Yea	3. Time of	Death
	/Medi		Clyde Eugene COLL		10					Novem	ber	29 200:	5 7:28	PM
	Examir	ner	4a. Facility Name (If not institution, give			,	· .		Location of	Death		4c. County of De		
			Washington County 5. Social Security Number 6. Se			last birthday)	If Under	-	stown If Under 2	4 Hrs 0 Data of	Diah	Washing		
	Funeral Director			M 2□F	84		Months	Days	Hours	Min. B. Date of (Month, Dec.			irthplace (State of Country) ennessee	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Ci	ty Limits
	Mary -feh	ţō	Maryland Washin	gton		Hagei	stown	ı					1 ☐ Yes	2 🔀 No
	r 288	irec	10e. Street and Number				10f. Zip				10g.	Citizen of What (Country?	
	h with	a D	11208 Pepperbush	Circle				2	21740			USA		
	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow deal Examiner must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Deced	lent of Hi	spanic Origi	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An		
9	or its	F	1 Never Married 2 Marned	1 Tes 2 X			1 Yes			rueno nican, etc.)		Black, Wi		
003	ural',	d b	3 Widowed 4 Divorced	Year or Dates:					opechy.			Specify:	white	
21215-0036	nat	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		16a. Deced (Give	dent's Usua kind of wor DO NOT us	k done a	urina most i	of working	16b.	. Kind of Busines	s/Industry	
12	fited within Hygiene.	Ę.	Elementary/Secondary (0-12)	College (1-4or	5+)				ofing		Ι,	construc	tion	
9	filed Hygi other	0	17. Father's Name (First, Middle, Last)							s Name (First, Mid			01011	
an	ould be Mental mrked o	To B	Noah Webster Coli	lins					Nann	ie Ellen	Bur	ton		
Maryland	should and Men is marke	-	19a. Informant's Name/Relationship (T)	pe, Print)		19b. Mailir	ng Address	(Street a	nd Number	or Rural Route Nu	mber, Cit	y or Town, State	Zip Code)	
	D € 2 ±		Leona F. Collins -	- wife		_			ısh Ci	rcle, Ha	gerst	town, Md	. 21740	
ore			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	lemoval from State	CE	lace of Dispo emetery, cren	natory`or o	ther place		Date		Location - City of		
Ë	nit. Pag ntment rtant: njury	99	4 □Donation 5 □ Other (Specify)		Sal	tillo				.2/3/05		ltillo,		7ania
Baltimore,	permit. Page Depertment of Important: If any njury or once.		21. Signature of Funeral Service Licens	n Du	rre	1			s of Facility on Bou	MINNIC levard, l		NERAL HOrstown,		4 0
8760,	Physician /Medical Examiner per physician and physician items of physi	icai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	idnos ofy:	ha		ma	~ ~	Lan		Initerval Best	
P.O. Box 68	the death certifica y the attending phached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pro				_	23d. Date of d Month		/ear
	uires that r signed b	by	Part II. Other significant conditions con		out not resu		aderlying ca		n in Part I.			o use contribute	to the cause of de	
Sor	w requ	iete		a cua			3.4		-	24a. W				
al Records,	isn: The law rtificate has stor, page 2 s	Completed			have	Ç-4-		spec	can	au au	itopsy informed?	prior to death?	utopsy findings a completion of ca s 2 \(\text{No} \)	
Vital	sicism: certific rector.	Be	25. Was case referred to medical examiner?	ospital:				Othe		f Death Check on				
of	Phys rthis ral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Impati 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		3c. Injury Work	at		esidence oe how in	6 □Other (Sp jury occurred	ecify)	
Division	Hospital or Attending 14 hours after death. Funers! Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At hor tc. (Specify,	me, farm, stre	eet, factory	office		28f. Location City or	n (Street Town, Sta	and Number or F ate)	iural Route Numi	oer,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best ner: On the basis of and manner st	of examinati	vledge, death ion and/or inv	occurred a restigation,	it the time in my op	e, date and inion, death	place, and due to ti occurred at the tim	he cause ie, date a	(s) and manner a and place, and du	s stated. e to the cause(s)	
	To the company	Σ	29b. Signature and title of certifier				29c	License	number		1	Date signed (Mor		
)			-tout m	D				918	019		~0	V 30,	2005	
1.	,		30. Name and address of person who co	mpleted cause of			,							
CH.	1-3		31. Date filed (Month, Day, Year)			340	MIL	4 5	7 1	AKERST	OW	v mo	マノフレ	0
	Sta Registr		DEC 0 1 2	005 32. Healst	ar's Signati	B. Di	serte	,						

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H			2005	4037	8
	Physici	an.	Decedent's Name (First, Middle	ı, Last)				Date of Death Month	Day Year	3. Time of D)eath
	/Medi		Bonnie	L.	Cogar			November		8:10	a ^M
	Examir	ier	4a. Facility Name (If not institution				Location of Death	_	4c. County of Death		
			5. Social Security Number		enter ge (In yrs. last birthday		Frederic If Under 24 Hrs.		Calvert		
н	Funeral Director		235–20–5292	1□M 2🌠 F	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	1923 Vir	pface (State or intry) Jinia	roreign
24	p.		Usual Residence of Decedent					may 4,	1923 VIII	JIIITA	
	anylar ehow	_	10a, State 10b. County		10c. City, Town or L					10d. Inside City	
	he M	ecto	MD Ca.	lvert			ake Beach			1 🗆 Yes 2	
	death with the Maryland rms 23a or 28a-f ehow r must be notified at	Funeral Director		11 D-/		10f. Zip Code	00730	10g	. Citizen of What Cou	intry?	
	na 23	era	4700 Camp Roose	12. Was Decedent	Ever in U.S. 13		20732	acify Vas or No-	USA 14. Race - Amer	ican Indian	
ထ	or Iter		1 Never Married 2 Marri	Armed Forces: ied 1 ☐ Yes 2 🛣	? No	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White		
Š	72 hours after natural', or ite	l by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: wh:	ite	
21215-0036	72 h	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dece	dent's Usual Occupa	ation Juring most of work	ing 16	b. Kind of Business/Ir	ndustry	
121	han within	пр	Elementary/Secondary (0-12)	College (1-4or	5+)	kind of work done of DO NOT use retired,)		,		
	filed within Hygiene. Ither then "		11 17. Father's Name (First, Middle,	(ast)	n n	omemaker	19 Mother's Name	(First, Middle, Ma	own home	!	
Maryland	d be ental	o Be		ıther Hoov	or		Geneva	Zula	Rexrode		
7	should nd Men s marke umatic	J.	19a. Informant's Name/Relationsh			ng Address (Street a			ity or Town, State, Zi	o Codel	
Z	and 2 Balth a n 27 is		Beverly L. Butl	er. daughte					oeake Beac		0732
Baltimore,	- T & =		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		-	c. Location - City or T		,,,,,
Ĕ	Pages nent of I ant: If Ito ury or o		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			n National		/2005 Ar	lington,	VA	
alt	Departr Departr Importu eny inj		21. Signature of Funeral Service I	icensee		2. Name and Addres					
W	20 E 2 9		William	R.600	-	Rausch Fur	neral Hom	e, P.A.,	Owings, M	D 20736	
			23a. Part1. Enter the disease, or shock, or heart faifure. List	complication that cause only one cause on each li	ine.					Approximate Interval Betwe	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. (or	igestive.	Heart 1	Falure			Onset and De	atn
	/Medical Examiner		rosaking in dodan,	Due to (or as	aconsequence of):						
- 18 - 2	- T	er	Sequentially list conditions,	b. Due to for as	à consequence of).						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		. ,						
Ó	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate hy	dical		d.							
9 ×	eath certific attending p	(D)	IF FEMALE:								
Вох	sath c attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of deliver	ery Day Yea	ar
o.	that the de led by the a detached f	yslo	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□ Unknown	t time of death 5L	Other (specify)				, , , ,	"
J.	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as I	ьу Р	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	nderlying cause give	n in Part f.	23e. Did tobac	co use contribute to the	he cause of dea	th?
Records,	w require: been sig							1 ☐ Yes	2□No 3□Prot	oably 4 Unk	known
ပ္ပ	law requasis been 2 should	Completed						24a. Was an	24b. Were auto	psy findings ava	ailable
		mo						autopsy performed	i?,, death?	mpletion of caus	se of
Vital	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death		12.103	20140	
	Attending Physician: r death. ector: After this certifice by the funeral director.	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie			4 LX Nursing Hon	ne 5 Residence	e 6 □Other (Specif	y)	
טח	ding F h. After funera	on:	27. Manner of Death 1 Natural 5 ☐ Pending		y Year) 28b. Time of Injury	Work'		28d. Describe how in	n _f ury occurred		
Division of	or Attendi after death. Director: A d in by the fu	ertiflcatlon;	2 Accident investigation investigation and accident formula investigation and accident formula investigation inve	ot be 200 Place of Ini	ury - At home, farm, str		es 2 No	006 Lanatina (Ct.)			
	7 5 7 6	ertii	4 Homicide determin	building, et	c. (Specify)	eet, factory, office		City or Town, Si	t and Number or Rura tate)	II Houte Numbei	
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	O	29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, death	occurred at the time	e, date and place, a	ind due to the cause	e(s) and manner as s	tated.	
	n 24 he Fu	edical	(Check only 2 Nedical E	xaminer: On the basis of and manner sta	examination and/or in	vestigation, in my opi	nion, death occurre	ed at the time, date	and place, and due to	the cause(s)	
	Tot E	Σ	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)	
			14	1	M.D.	05	1949		11/28/05		
	15		30. Name and address of person	A Ilx Hac	leath (Item 23a) Type.	Print)	200	200 C.	0 1	246	
S. 13	- 10070 VOM		31. Date filed (Month, Day, Year)	7. [16 1705] 32. Region	Signature /	, Juik 3	WO 110	nce 1/6	dente,	no ZD	678
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	1	For State Registrar	State of Marylan		artment of H rtificate of L			Reg. N	UUD	40379
Physician		I. Decedent's Name (First, Middle, Las Michael Louis Ca					2. Date of Month Nove	D	25, 20	3. Time of Death 3:20 A
/Medical Examiner		a. Facility Name (If not institution, give			4b. City, Town, or	Location of D			c. County of I	
45 July		Calvert Memorial Social Security Number 6. S		last hirthday	Prince	Freder				t County
Funeral Director			Km 2□F 54	Yrs.	Months Days		Jan.	Day, Yea.		Birthplace (State or Foreig Country) ashington. I
\$ #020	\vdash	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	, Town or Lo	ocation					10d. Inside City Limi
items 23e or 28e-f ehow rier rust by ricilized at		MD Calvert	County	unkirk						1 ☐ Yes 2 💆 N
be notified	3	10e. Street and Number	Country	(dilitari	10f. Zip Code			10g. C	itizen of Wha	it Country?
s 23a		6307 Westmont Co	urt 12. Was Decedent Ever in U.	C 12	20754	icoanic Origin	2 (Specify Ves o		.S.A.	American Indian,
of, or items 23s examiner must by Funeral		11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	uerto Rican, etc.)	Black, \	white, etc. White
it, the Medical E	hipiered	15. Decedent's Ed (Specify only highest gra Etementary/Secondary (0-12)	ducation de completed) Coflege (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working		Kind of Busin	
it the	5	11 17. Father's Name (First, Middle, Last)		Plu	mber	18 Mother's	Name (First, Mid		elf-Em	ployed
atic even	2	Nick Caparella					erine Di			
sumat	-	19a. Informant's Name/Relationship (ng Address (Street					
itam 27 other tr		Terry Caparella 20a. Method of Disposition			Westmont sition (Name of			-		y or Town, State
t: # its		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	emetery, cre	cemetery or other place		ov. ^{Date} 2005			r, Maryland
any injury or ance.	+	21. Signature of Funeral Service Licer								lvert, P.A.
r a	1	Michael W. 1	<u>e</u>				. -	-	Owing	s, MD 20736
ician dical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a	n. Do not en	ter the mode of dyin	g, such as car	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
rial-transit	Cal Evallille	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a co	uence of)	Bowel	Disea	ese			YEARS
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shed for use as the	Filysiciatumed	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)	,			23d. Date o Month	,
e j	2	Part II. Dther significant conditions of	contributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.				ite to the cause of death? Probably 4 Unknow
CV I	Completed						a	Was an autopsy performed?	prio	re autopsy findings availat r to completion of cause of th? Yes 2 \(\sum \text{No} \)
ector, pag	9	25. Was case referred to medical examiner?	Hospital:		nt 3 DOA Oth	O.C.	Death (Check o			
al dir	0	1 Yes 2 XNo 27. Manner of Death	28a. Date of Injury	28b. Time o	III OLI BOX	1 110101	ng Home 5 1		6 Other ((Specify)
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	edical		nysician: To the best of my knominer: On the basis of examination and manner stated.							
duoo	ž	29b. Signature and title of certifier	gale		29c. Licens	e number 2965	57		Pate signed (A	Month, Day, Year)
		30. Name and address of person who Charles A. Judg	ge, M.D. 110 H	Hospita		Suite 3	310, Pri	nce F	rederi	ck, MD 20678
State Registra	e	31. Date filed (Month, Day, Year) NOV 2 8 2005	32. Registrar's Sign	ature						
7 Rev 1/200		1 0 2000	PERSONAL IT IS.	DEALL						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené UU5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Contee **Physician** Elizabeth 10:10P M Nov. 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth July 21,1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🕏 F Maryland 83 212-34-3403 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examinitation until be notified at once. 1 Yes 2X No Owings Calvert Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20736 1250 Skinners Turn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bfack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Black Completed by 3 ♥ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Someone Else's Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tony Rice Morsell Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 W. Chesapeake Beach Rd. Owings, MD 20736 Helen Spriggs/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State Carter's UMC Cem. 11/29/05 Friendship, 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. 21. Signature of Funeral Service Licenses Funeral Home Pr. Fred.,MD 20678 Gladys 9. sewe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of). the attending physician Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? ŏ 4 Pregnant at time of death 5 Other (specify) 9 Unknown vare nas been signed by , page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2000 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. patient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

P.O. Box 68760, Division of Vital Records,

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifie

29a. Certifier

30. Name and address of person in completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

3

32. Registras Signature 2005

MD

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

7

29d. Date signed (Month, Day, Year)

05

0

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 James William Cotter Nov 28 0640 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Conta 54013641 Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1XM 2□F 80 015-05-5876 Director Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or itams 23e or 28e-f show the Medical Exercity or most be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5774 Cork Street 21801 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 1946 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1943-1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1945 Specify: þ 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Child and Family marked other than Elementary/Secondary (0-12) College (1-4or 5+) President/CEO Welfare Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be finance in and Mental I James William Cotter, Sr. Alice Foley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vortant: If Item 27 is v injury or other Muriel E. Cotter/Wife 5774 Cork Street, Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11/29/2005 Delmar, Delaware 21. Si mulure of uneral Service I Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA **Physician** /Medical Due to (or as a consequence of): Examiner HEMPRAHAGIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 DUnknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, HYVERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed SEIZURE DISORDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? ATRIAL FIBRILLATION 2 No 1 🗌 Yes 2)X No of Vital 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: ___npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28b. Time of Injury Medical Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation after death.

Diractor: Aft
d in by the fun 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 within 24 hours aft To the Funeral Di completely filled in To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0060515 who completed cause of death (Item 23a) (Type, Print) 614 B SALISBURY MD 21804. EASTERN SHINE DE 32. Registrar's Signature State Registrar

		State of Maryland / Department of State Amended 26,11/30/05,LDB,DOR Certificate of Certificate o			g. No.	4 0 3 8 2
hysici /Medic Examin	cal	Pierre N. Charbonnet Ju 4a. Facility Name (If not institution, give street and number) 4b. City, Tow	vn, or Location of Death	Nov. 24,	Day Year 2005 4c. County of De	11:48 a
uneral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y Months Day Months Day 1 Months D	oridge Bar If Under 24 Hrs. Bays Hours Min.	8. Date of Birth (Month, Day,) Dec. 22,		nester othplace (State or For Sountry) ifornia
Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Florida Escambia Pensacola	*			10d. Inside City Li
3e or 2	I Dire	106. Street and Number 106. Zip Cod 3250		100	g. Citizen of What C US	
al, or items 2	by Funeral Directo		of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:	
Importent: If itam 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic avant. If we worked Examiliar, ust be multiply at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Or (Give kind of work do life. DO NOT use re	one during most of work atired)	ing	5b. Kind of Busines	
itic avant.	To Be Co	12 7 Officer Unit 17. Father's Name (First, Middle, Last) Pierre Numa Charbonnet	18. Mother's Name	Joan Rog	aiden Sumame)	-/MIIILary
27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Hildegarde C. Leffen/Daughter 19b. Mailing Address (Str. 5932 Horns)	reet and Number or Rura Point Rd.,	al Route Number, C Cambridg	City or Town, State, se, MD 21	Zip Code) L613
ury or othe		20a. Method of Disposition 1	nalCemeteryi	1/26/2006		on, Virgin
any in	9	Wignature of Funeral Service Licensee 22, Name and Ar Mid Short 2272 Huch	ddress of Facility Te Cremation Ison Rd., Ca	n Center, ambridge,	P.O. Box MD 2161	
ician dical		23a Part1. Enter the essease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	dying, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Dea
the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Tiyrs
detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify 9 ☐ Unknown			23d. Date of de Month	olivery Day Year
should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		cco use contribute t	o the cause of death robably 4 □Unkr
CV	Completed			24a. Was an autopsy performe 1 Yes 2	prior to	utopsy findings avai completion of cause s 2 \(\square\) No
neral di	ertification; To Be	77. Manner of ath 28a. Date of Injury (Month, Day Year) 1 Limitural 5 Pending (Month, Day Year)	Other: 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Horning Administration 4 Nursing Ad	28d. Describe how	e 6 X Other (Spe	
completely filled in by the fu	O	28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the		City or Town, S		
completely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in mone) and manner stated.	ense number	ed at the time, date	and place, and du	th, Day, Year)
		May MAN. More My	10/100		11-28-6	/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 24, 2005 onawal andol /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrsv 8. Date of Birth (Month, Day, Year) Dorchester General Dorchester 5. Social Security Number 214-30-9382
Usual Residence of Decedent Birthplace (State or Foreign Country) **Funeral** 100 M 20 F Months Yrs. 3.3 Delaware Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or then "neturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 PYes 2 No Cambridg Director MD 10g. Citizen of What Country? 10f. Zip Codé 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 21613 1001 Melia Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Black Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other then Processing-Line Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 Is marked oth any injury or other traumatic event 2008. Be Conaway Gertrude ပ္ James Tohnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type, Print) 306 Grant Street-Seaford, Delaware Annette annon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition *4 Donation 5 Other (Specify) Washington Cemetery 12/3/05 Hurlock MD

21. Signature of Funeral Service Licensee 2. Name and Address of Facility

Henry Funeral Home, C. A.

Henry Funeral Home, C. A.

23a. Part. Enter the disease, or complications that caused the death of the shock, or heart failure. List only one cause on each ine.

Immediate Cause (Final Immediate Cause (Final disease or condition resulting in death) state Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed sician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To 1 🗌 Yes Inpatient Pate of Injury (Month, Day Year) 27. Manner of ath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29d. Date signed (Monty, Dey, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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who completed cause of death (Item 23a) (Type, Print)

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Terre

30. Name and address of person

		•	For St - State Registrar	ate of Maryland / D	Department of Certificate of			iene	L0384
	Dhysiair	_	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Ye	3. Time of Death
	Physicia /Medic	al .		rd B. Heller			De c em		out 14:00
}	Examin	er	4a. Facility Name (If not institution, give stree			n, or Location of De	ath	4c. County of D	
			SunBridge Care Cen 5. Social Security Number 6. Sex	7. Age (In yrs. last birt	Elkt	ear If Under 24 H	rs. 8. Date of Birth	9.	Birthplace (State or Foreign
	Funeral Director		176-42-7947 ^{1□ M}	- 16A -	Yrs. Months Da	lys Hours Mi	oCT 11,	Year)	ermany
	P _		Usual Residence of Decedent	10c. City, Town	n or Location				10d. Inside City Limits
	arylar show	5	10a. State 10b. County						1 ☐ Yes 2 1 No
	the M	ecto	Maryland Cecil 10e. Street and Number	Unes	apeake Cit		1	0g. Citizen of Wha	
	Mith Sa or	2	15 Tower Road		219			United	
	death ma 2;	Funeral Director	11 Marital Status 12. V	Vas Decedent Ever in U.S. Armed Forces?	13 Was Decedent		(Specify Yes or No-	14. Race - A	American Indian, White, etc.
9	after or ite		1 ☐ Never Married 2 📉 Married	☐ Yes 2 MNo f Yes, Give	1 ☐ Yes 2 🔀		onto modifi, oto.)	Specific	
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212	with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker			In Her	Own Home
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ylaı	Menta Menta arked	To	Heinrich Bellingra				Maria Wie		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Merith Hygiene. Important: if Item 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.		19a. Informant's Name/Relationship (Type,		. Mailing Address (Sti				
e, P	1 and Health em 27 ther t		Dr. Melvin S. Helle 20a. Method of Disposition	20b. Place of	5 Tower Ro		Date	20c Location City	or Town State
Baltimore,	ages nt of 1 t: If Ita		1 ☐ Burial 2 ☒ Cremation 3 ☐ Remo	val from State cemeter	ry, crematory or other erris & Co. I	(Place) Dec	ember 8,	West Che	ester,
Ħ	nit P entme ortani injury		21. Signature of Funeral Service Licensee	I N.A. Fe				Pennsylv	vanıa
B	Depe Impo any ii		Married &	Dieles	103 W. S	ome for Fi Stockton S	nerals, P Street, El	.A. kton, Mar	ryland 21921
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	Physician		Immediate Cause (Final disease or condition			CVA			Onset and Death Z mouths
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of): A+	viel [brilleti	1-2-	7
в		-	Securitally list conditions b. —	Due to (or as a consequence		. 1-1 71	011/12/1		7 years
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		Con					perfor 1 ☐ Yes		th? Yes 2□ No
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Division	Attendil r death. ector: A by the fu	ifica	a Classister & Claud not be -	8e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, of	fice	28f. Location (S City or Town		or Rural Route Number,
	talor A rs after al Direc	Certification:	Tomodo	building, etc. (apochy)					
	To the Hoapital or Attenswithin 24 hours after deatl To the Funeral Director:	edical		an: To the best of my knowledg On the basis of examination ar and manner stated.					
	To the He within 24 To the Fu	Me	29b. Signature and little of certifier		29c. Li	cense number	2	29d. Date signed (A	Month, Day, Year)
	->-0		> 1H. Harks	y /17	10/	5314	j	Decampe	7.2005
	T		30. Name and address of person who comp	leted cause of death (Item 23a)	(Type, Print)		/	1/	= 1/=
	D		H Farkas MP	32 Aegistrar's Signature	NorThe	rn Cho	sapente	prepice	Elklon,
	Sta Regist	ate rar	31. Date filed (Month Par Year) 4 2005	32 negistrar's Signature	Sperker				7, 2005 Ellton, M

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day HELENE MITROFANOFF DEGARIE /Medical DECEMBER 3,2005 2:46 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 101 WESLEY DRIVE, APT. 121 PLATA CHARLES If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 ☑ F Director 578-72-9598 Yrs. FEB. 28,1928 YUGOSLAVIA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "neturel", or Items 23a or 28a-f show treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits MARYLAND CHARLES Yes 2□No LA PLATA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 WESLEY DRIVE, APT. 121 20646 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-∰ Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2/☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ Specify: Specify: 3 ☐ Widowed ★ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOK STORE WORKER KAMKIN BOOKSTORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PAUL MITROFANOFF NADENE BYSTROFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 s it of Health an NATHALIE FIKE-DAUGHTER 6220 GOPHER CT., WALDORF, MD other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Importent; If itel
eny injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) M E METROPOLITIAN CREMATORY 12-6-05 ALEXANDRIA, VA 21. Signature of Juneral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on aused the death. Do not ente Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequer **Examiner** neelen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sequence of): Examiner Due to (or as a physician and the burial-transit Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetat death in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Vital 2. No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Tes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22574 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120,00 Old Line Center, Waldorf. wood MD. MB 20602 earther filed (Month, Day, Year) State DEC 1 4 2005 Registrar

			T = For State Registrar	State of M	aryland / D		ent of He ate of D			time the time of	5 4	0386
		П	Decedent's Name (First, Mide	die, Last)				- Outr	2. Date of Deati			3. Time of Death
	Physici /Medio		Lois Elizabeth	Durst					Month December	Day 200	Year 05	1307 ^M
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			4037 Chestnut				antsvi		,	Garre	tt	
	Funeral Director		5. Social Security Number 217–18–4295	6. Sex 7. Aç 1 ☐ M 2 X F	ge (In yrs. last birth 81	rs. Mont		Hours Min.	8. Date of Birth (Month, Day, Mar. 13,	Y eari	9. Birthplac Country Ohio	e (State or Foreign)
Т	pud }		Usual Residence of Decedent 10a, State 10b, Count	v	10c. City, Town	or Location					104	Inside City Limits
	Maryla f eho	ō				or Eodalion	C				100.	1 ☐ Yes 2X No
	the 1	Director	MD C	arrett		10f.	Grants Zip Code	ATTTE	10	g. Citizen of Wh	at Country	?
	h with		842 Chestnut F	Ridge Road				21536		USA	·	
	deep m	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was De	specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No-		American White, etc	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 te marked other than "naturel", or Items 23a or 28e-f ehow any Injury or other treumatic event, the Medical Examiner hour the notified at once.	by	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 ☐ Yes 2√∑			s XXI No	Specify:	riicari, etc.)		white. Bic	
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Maryland	d be f antat h red of	o Be	Edward O. Jenk					Minta Mi		alden Sumame)		
Σ	shoul nd Me mark	٦ و	19a. Informant's Name/Relation		19b.	Mailing Add			al Route Number,	City or Town, St	ate. Zip Co	de)
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Ĕ	Pag ment ant: I		4 □Donation 5 □Other (ille	Cemete	ry, Dec	10,2005	Grants	sville	e, MD
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ð	Phys this ral dir	70	1 Yes 2 No 27. Manner of Death	1 Inpatie			DOA Other:	4 Nursing Hol	me 5 Resider 28d. Describe hov			Scene
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L.			high	i mid			OCME		De	cember,	5. 20	005
	10		30. Name and address of person		leath (Item 23a) (T			n Street		ore, Mai		
	Sta		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature		TI TELL	n DITEEL	nailill	ore, rial	гати	1 21201
	Registr	ar	DEC -	6 2005	was Sh	Anace	820					

			For State Registrar	St	tate o	f Marylar		artment of Hertificate of L		ind Menta		I. No.)5 L	038	37		
	d Property		1. Decedent's Name (First, Mid	dle, Last)							te of Death	Day	Vana	3. Time of	f Death		
	Physici /Medic			Georg	ia H	. Deans	5				zember		2005	8:45	A M		
	Examir		4a. Facility Name (If not institut	ion, give stree	at and nur	nber)		4b. City, Town, or	Location of	f Death		4c. Cou	inty of Death				
			Stella Maris					Timon				Baltimore					
	Funeral Director		5. Social Security Number 414 24 9512	6. Sex 1 ☐ M	2 🔀 F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mi	te of Birth onth, Day, Y		Cour	place (State on try) CSSEE	or Forei gn		
	pu ,		Usual Residence of Decedent			10- 0	- T 1-										
	aryla shov	_	10a. State 10b. Coun				ty, Town or Lo						1	10d. Inside C	ity Limits 2 ⊠ No		
	8a-f	ecto		timore	!	Ca	itonsvi					0			2A)140		
	with t	吉	10e. Street and Number	Dood				10f. Zip Code			100		of What Cour	,			
	eath	era la	1127 E. D'Long		Nas Dace	edent Ever in U	18 13 1	21228	enanio Orio	in? (Specify V	as or No-		ted Sta				
36	iges 1 and 2 should be tiled within 72 hours atter death with the Maryland it of Heatih and Mental Hyglene. If Item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be multised at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorce	arried 1	Armed Fo 1 ∐Yes If Yes, Giv	rces? 2X No re		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:	, Puerto Rican,	etc.)	E	Black, White,	etc.			
21215-0036	hour tural	Pa Pa		ent's Educatio	Year or D	a105:	16a Dece	dent's Usual Occupa	tion		16	h Kind of	Whi f Business/Inc				
15	in 72	Set	(Specify only high	nest grade cor	mpleted)		(Give	kind of work done di DO NOT use retired)	urina most	of working	10	ib. King of	Dusinessin	Justry			
12	lane.	Completed	Elementary/Secondary (0-12	'	College (1 2	-4or 5+)	Bo	okkeeper				Reta	ail				
	Hygie other	BeC	17. Father's Name (First, Middle	e, Last)					18. Mother	's Name (First,	Middle, Ma						
an	Mental Mental arked o	To B	John Hunigan						Nett	ie Booh	er						
Maryland	2 should be tiled within and Mental Hygiene. Is marked other then sumatic event, the M.	-	19a. Informant's Name/Relation	nship (Type, I	Print)		19b. Mailir	ng Address (Street a	nd Number	r or Rural Route	e Number, C	City or Tov	wn, State, Zip	Code)			
	1 and 2 Health a tem 27 is		Craig Deans/So	n			151	Hewett Roa	ad Wy	ncote.	PA 19	095					
ē,	ot He item		20a. Method of Disposition				Place of Dispo	sition (Name of natory or other place	1	Date			on - City or To	wn, State			
Baltimore,	permit. Pages Department of I Important: If ite any injury or or once.		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		oval from	State	_	Forest Ve	1	2-6-200	5 0	wings	s Mill:	s. MD			
alt	permit. Page Department important:		21. Signature of Funeral Service	e Licensee	101			. Name and Address							Inc.		
<u>m</u>	Dep imp any		Dhen Col	mo U	NEX	1		112 01d C									
1			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications on complications	on that cause on e	aused the dear ach line.	th. Do not ent	er the mode of dying	, such as c	cardiac or respi	ratory arres	t,		Approximat Interval Bet	ween		
E	Physician		Immediate Cause (Final disease or condition	а	CERE	BROVASO	III.AR A	CCIDENT						Onset and I	Death		
	/Medical Examiner		resulting in death)			or as a consec		OULDING									
	LXUITITICI	_	Sequentially list conditions,	b	Chick has d	NATIONAL REPORTS											
	ed isit	lne	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	≺	Cua to (or as a nonsec	frieude (at).										
	xecui and al-trar	Examiner	that initiated events resulting in death) Last	c	Due to (or as a consec	quence of):										
8760,	cate be executed physicien and the burial-transit	dlcal E		4 =													
687	iticate g phy as the	ed		0.													
Вох	eath certiti attending I for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. lí	f yes, out	come of pregn	ancy	Te				23d. I	Date of delive	ery			
	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 X No	4	4∐Pregn	irth 2 ☐ Feta ant at time of c		JEctopic pregnancy] Other (s <i>pecify)</i>				1	Month	Day	Year		
P.0	that the de led by the a detached i	hys	9 Unknown	-	9∐ Unkno	wn						1					
	es the	by F	Part II. Other significant condi	tions contribu	uting to de	ath but not res	sulting in the ur	nderlying cause give	n in Part I.	23	e. Did toba	cco use co	ontribute to th	e cause of d	leath?		
ord	w requir been si should l									_	1 🗌 Yes	2 🗆 No	3 Prob	ably 4 🛣	Jnknown		
Records,	E 25 C	Completed								24	a. Was an autopsy		b. Were autor	psy findings	available ause of		
= =	(0 LT	Con								1	performe Yes 2		death? 1 ☐ Yes				
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	-						of Death (Chec	k only one)						
of \	di di	은	1 ☐ Yes 2 📉 No	Hospi	1 🗇 1		ER/Outpatien		4 🗀 19UI:	sing Home 5	Residenc	e 6 🛣	Other (Specify	HOSP	ICE		
n		on:	27. Manner of Death 1 X Natural 5 ☐ Pend		8a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	Work'			scribe how	injury occ	urred				
Si	e att	icat	3 ☐ Suicide 6 ☐ Coul	d not be	na Diana	at laine. At h			es 2 N		-N (Ch	-4					
Division	after death after death Director:	Certification;	4 Homicide dete	rmined 2		ng, etc. (Special		eet, factory, office		Cit	y or Town, S	stano Nui State)	mber or Rura	Houte Num	Der,		
	spita lours nerai tilled		29a. Certifier 1 X Certify	/ing Physicia	n: To the	best of my kno	owledge, death	occurred at the time	a. date and	l place, and due	to the caus	se(s) and	manner as st	ated			
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely tilled in by th	edical	(Check only 2 Medical one)	al Examiner:	On the ba	sis of examination of stated.	ation and/or inv	estigation, in my opi	inion, death	n occurred at th	e time, date	and plac	e, and due to	the cause(s)		
	Within To the Comp	×	29b. Signature and title of certif	ier				29c. License			29d	. Date sig	ned (Month, I	Day, Year)			
				12-				D43	3725			11	129/	05			
10	a2		30. Name and address of person	n who comple	eted caus	e of death (Iter	т 23а) (Туре,						-				
			DR. TARIQ MA) DULAN		LEY RD.	TIMON:	IUM, MD	21093	3					
- PS.	Sta Registr		31. Date filed (Month, Day, Yea		1 400	gistrar's Signa	ature	Carl .									
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DHMH 17 Rev 1/2001

Registrar

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2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death .35 **Physician** THOMAS DeMAY, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year MAR • 20, 1 5. Social Security Number Age (In yrs. last birthday) Pirthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 218-16-4068 80 1925 MAR. OHÍO Usual Residence of Decedent deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show WV 1 ☐ Yes X☐ No MINERAL RIDGELEY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 CALDWALDER STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: item 27 is marked other than "naturel, or items other traumatic event, the Medical Examinar m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PEPSI COLA COMPANY Elementary/Secondary (0-12) College (1-4or 5+) VENDING MACHINE OPERATOR 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be PASQUALE DIMAIO CARMELA ALBARANO 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN DeMAY / SON 3 BROWNING STREET, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) important: if ite.
eny injury or oth Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State PETER & PAUL CEM. 12/03/2005 4 Donation 5 Other (Specify) CUMBERLAND, MD 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, 21. Signature of Funeral Service Licens 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the at a be deteched fo 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown been si should l 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No has certificete 1 ☐ Yes :: After this certifice e funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) Road, Cumberland, MD n KS 32. Registrar's Signature 31. Date filed (Month State Registrar

			1 - For State Registrar	State of Ma	aryland /	Department of I Certificate of		Mental Hy	giene 05	40390
	DI		1. Decedent's Name (First, Middle, L	.ast)				2. Date of De	Day Your	3. Time of Death
	Physici /Medi		Grace Ellen	Davis				Nov. 2	25, ^D 2005 Year	11:00 p.Mm.
	Examir		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Death		4c. County of Dea	ath
			7403 Karen Aven	ue			Easton		Tal	bot
	Funeral Director		122-32-0070	Sex 7. Agr	e (In yrs. last bi	rthday) If Under 1 Year Months Days		8. Date of Bir (Month, Da Oct. 1	9. Bi 28, 1941 N	rthplace (State or Foreign Jountry) EW York
6	Maryland -1 ehow lied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Talbo	t	10c. City, Tov	vn or Location	Caston			10d. Inside City Limits
Es	death with the ms 23e or 28a	Funeral Director	10e. Street and Number 7403 Karen Aven	ue		10f. Zip Code 216	SOT		10g. Citizen of What C	country?
-	leath	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No		erican Indian.
920	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 le marked other than "naturel", or Items 23e or 28a-f ehow other traumatic event, it a M. Jical Examiliter is ust be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Fivorced	Armed Forces? 1 ☐ Yes 2 ∰ If Yes, Give Year or Dates:	40	If Yes, specify Cub		Rićan, etc.)	0	
Maryland 21215-0036	within 72 ho ene. than "natur re M. dical	Completed	15. Decedent's (Specify only highest g	Education trade completed) College (1-4 or 5	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work d)	king	16b. Kind of Business	/Industry
21	ad wit	Con	Elementary/Secondary (0-12)		Adr	ninistrative	Assistar	nt	County Gov	ernment
b	be filed tal Hygi d other event, t	Be (17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle	, Maiden Sumame)	
<u>×</u>	should bind Ment a marked umatic	2	Daniel Guinan					Barry		
lar	2 sho and lema		19a. Informant's Name/Relationship			o. Mailing Address (Street				
	and lealth m 27		Michael Edward D	avis/Son	13	1390 N. Cana	da Creek			
o o	Pages 1 nent of H ant: If ite ury or otl	13	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from State		of Disposition (Name of ary, crematory or other pla		Date	20c. Location - City or	Town, State
턡	Emen tent: jury		'4 □Donation 5 □Other (Spec		MidSho	oreCremation				
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra <u>9068</u> .	6	21 Signature of Funeral & rvice Lice	at Pene	wel	Mid Shore 2272 Huds	e Crematio con Rd., C	n Cente Cambridg	er, P.O. Bo e, MD 216	x 1464, 13
	Physician	1 I	23a. Pan1. Enter the disease, or conshock, or hear failure. List only immediate Cause (Final disease or condition	7 7 7 1	,	no inter the mode of dyi		or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	b	a consequence					8 mmHs
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	c	a consequence					
8760,	9 % 0	cat	rooding in additity East	d	a consequence	or):				
P.O. Box 68	Physicien: The law requires that the death certificate be this certificate has been signed by the attending physical director, page 2 should be detached for use as the bear director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	y		23d. Date of de Month	livery Day Year
	uires that signed b Id be deta	by	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the underlying cause given	ven in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
00	w require been sign	lete						24a. Was	an 24h Were at	utopsy findings available
al Re	icien: The law certificate has rector, page 2 a	e Completed	25. Was case referred to medical					autop perfo 1 Yes	prior to death? 2 No 1 Yes	completion of cause of
==	ysicien: nis certifica director, p	o Be	examiner?	Hospital: 1 Inpatie	nt 2□ER/O	3C DOA O#	26. Place of Deatl		<i>ne</i> dence 6 □Other <i>(Spe</i>	
Division of Vital Records,	ling After fune	H-13-	27. Mann of Death 1 Latural 5 Pending 2 Accident investigati	28a. Date of Injur (Month, Day		Time of 28c. Injury Wor	y at		now injury occurred	city)
Divisi	if or Attending after death. Director: After d in by the fune	Certification;	3 Suicide 6 Could not determine	be Disas of Isin	ury - At home, fa c. (Specify)	arm, street, factory, office		28f. Location (S City or Tow	Street and Number or Ru n, State)	ural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	Physicien: To the best of aminer: On the basis of and manner sta	examination an	e, death occurred at the tired of the tired	me, date and place, pinion, death occurr	and due to the ded at the time, of	cause(s) and manner as date and place, and due	stated. to the cause(s)
_	Fo th within Fo th	Me	29b. Signature and title of certifier	•		29c. Licens	e number		29d. Date signed (Mont	h, Day, Year)
			> Dunil S	M		1)3	9887		11/28/0.	
			30. Name and address of person who				1 1		1 3/3	•
			Dr. David Smith,	29466 Pin	tail Dr	., Easton, N	D 21601			
	Sta Registr		31. Date filed (Month (NOV) Ye3)	2005 32. Figistra	r's Signature	board				

			1 - For State Registrar	State of M	laryland		artment rtificate			and Me	_	giene Reg. No.	05	40391	
	Diam'r.		1. Decedent's Name (First, Middle, La.								2. Date of De. Month		Year	3. Time of Death	
	Physici /Medio		Linda Louise S	Seville	Dunni	ıng					Dec.	7 ,	2005	5:25 P	М
	Examir		4a. Facility Name (If not institution, give 20633 Slab Br				Fre	elar					County of Dea 11timo		
	Funeral Director		213-00-3000	ex 7.A □M 2⊠F	ge (In yrs. Ia 51	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da)Ct. 4	h <i>y. Year)</i> ! , 19.	C	thplace (State or Foreigountry) ryland	gn
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limit	ls
	a-f eho	ctor	MD Baltimo	ore	Fre	eelan	ıd							1 ☐ Yes 24☐ N	
	death with the Maryland ime 23e or 28a-f ehow r must be notified at	al Dire	10e. Street and Number 20633 Slab Br:	idge Roa	d		10f. Zip 2	Code 1053	3				en of What C ISA	ountry?	
980	or Its	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2X If Yes, Give Year or Dates:	?		Was Deced if Yes, spec 1 Yes 2		spanic Orig , Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)		4. Race - Am Black, Whi Specify:	erican Indian, te, etc. Vhite	
5-0	E 5 13	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	dent's Usua kind of won	l Occupat	tion uring most	t of working	7	16b. Kin	d of Business	/Industry	
21215-0036	within ane than	Completed	Florester (Consultation (O.10)	2+ College (1-4or	5+)	life. I Compu	kind of wor DO NOT us Iter					Ele	ctror	nics	
and 2	jes 1 end 2 should be filed within 7 of Health and Mental Hygians. If them 27 is marked other than "r other treumatic event, the Med	To Be Co	17. Father's Name (First, Middle, Last) Francis Brent		:						First, Middle, chaue		iumame)		
Maryland	nd 2 shou lith and M 27 is mar r treumat		19a. Informant's Name/Relationship (19b. Mailin 206	ag Address	(Street ar	Bri	dge	Road,	r, City or Fr∈	Town, State, eeland	Zip Code) 1,MD 2105	3
Baltimore,	pea 1 end 2 of Health 4 if Item 27 i		20a. Method of Disposition 1 □ Burial 2 XCremation 3(1)	Removal from State	20b. Pla	nce of Dispo	sition (Nam patory or oth	e of her place	,	Da			ation - City or	Town, State	
Ë	tment tent: tent:	1	*4 □Donation 5 □ Other (Specify)	Fun	n W eral	Home	€ &	j L		2005		rk, P	A	-
Bal	permit. Pagea Dapartment of I Importent: If Its eny Injury or o once.		21. Signature of Funeral Service Licen	See Luna		2.4	4 Sec	cond	St.	'Nev	Harte Free	edom	,PA 1	ortuary, 7349	
	nysician		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that cause one cause on each I	d the death.	Do not ente	er the mode	of dying	such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	10	13(tr						
	ם ≃	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	ence of):									
8760, <	icate be executed physician and s the burial-trensit	dical Examin	Cause (Disease of what y that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):									
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ds, P.	ulres that t i signed by id be deta	Š	Part II. Other significant conditions o	ontributing to death t	out not result	ting in the ur	nderlying ca	use giver	in Part I.			bacco use		the cause of death?	n
of Vital Records,	s been s been	Completed			-						24a. Was a	ın	24b. Were au	topsy findings available	8
- Re		EOC									autops perfor	nred? 2/Z No	death?	stopsy findings available completion of cause of	
/Ita	ysicien: ils certific director,	Be	25. Was case referred to medical examiner?	Hamilat.						of Death (Check only or	ne)			
5	<u>> </u>	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati		R/Outpatient		-	4 (140):		5 Resid		Other (Spec	oify)	4
on	dlng P. After funera	ton;	27. Manner of Death Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ny Year)	8b. Time of Injury	м 28	lc. Injury a Work? 1 □ Ye	at es 2.⊡N		d. Describe h	ow injury (occurred		
Division	or Atten affer deat Diractor: In by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At hom lc. (Specity)	e, farm, stre					f. Location (Si City or Town	treet and i n, State)	Nu mbe r or Ru	ral Route Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th complataly filled in by the funeral	Medical Co	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis of and manner st	f examinatio	ladga, daath on and/or inv	cocurred w restigation, i	t the time in my opin	, date and nion, death	place, and h occurred	d due to the e at the time, d	ausa(s) ar ate and p	d manner as lace, and due	stated. to the cause(s)	
	To the within To the comple	W	29b. Signature and title of certifier		+		29c.	License	number		2	9d. Date :	signed (Monti	n, Day, Year)	
)	_		• VUI	XX		10-1 CT	7	>0	>3°	82.	181	/	2/8	102	
	10		30. Name and address of person who	completed cause of c		23a) (Type, I	MD)	C	lle	20	Cen	JEN.	R	ant me	,
¢	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	rar's Signatur	Cock								1	

			For Stata Ragistrar	State of Maryland / Dep Ce	partment of Health and ertificate of Death	Mental Hygier	2005 10202
	Physicia /Medic		Decedent's Name (First, Middle, Last) MIHYUN N/M/N	EDDY	Al- Ch. Turn al-	DECEMBER	
	Examin Funeral Director	er	4a. Facility Name (If not institution, give st 2750 CONGRESS CO 5. Social Security Number 6. Sex		4b. City, Town, or Location of De WALDORF If Under 1 Year If Under 24 H Months Days Hours Mi	rs. 8. Date of Birth	
	므	ctor	574-72-5273 Usual Residence of Decedent 10a. State 10b. County MARYLAND CHARLI	10c. City, Town or	ORF		10d. Inside City Limits 1 ☐ Yes 2√∏No
	be filed within 72 hours after death with the Maryland stal Hygiene. In other than "natural", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	Funeral Director		OURT 2. Was Decedent Ever in U.S. 13 Armed Forces?	10f. Zip Code 20603 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		Citizen of What Country? U • S • A • 14. Race - American Indian, Black, White, etc.
5-0036	72 hours afte natural', or if	by	1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Educt (Specify only highest grade)	1 ☐ Yes. ② No If Yes, Give Year or Dates: ation	1 ☐ Yes 2 ☒ Xo Specify: edent's Usual Occupation to kind of work done during most of v	yorking 16b	Specify: ASIAN Kind of Business/Industry
Maryland 2121	should be filed within Marked other than " marked other than " matic event, ire Mex	Be Completed	Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	College (1-40f 5+)	e kind of work done during most of v DO NOT use retired) OMEMAKER 18. Mother's N		N HOME fen Sumame)
Marylar	2 should and Mer is marke sumatic	To E	SE JU JEON 19a. Informant's Name/Relationship (Type DAVID M. EDDY-HI		IN JA ling Address (Street and Number or O CONGRESS CT.		
altimore,	m O		20a. Method of Disposition 1 X Xurial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of Discometery, cr	ensition (Name of sematory or other place) ETERANS CEM. 1	Date 20c.	Location - City or Town, State ELTENHAM, MD
Ba	permit. Pag Department Important: If any Injury o once.		21. Signature of Funeral Service Licenses 22. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complication of the service of the	cations that caused he death. Do not e	Name and Address of Facility AYMOND FUNER LA PLATA, MAR nter the mode of dying, such as card		E, P.A. Approximate Interval Batween
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Breast Due to (or as a consequence of):	Carce		Onset and Death
8760, <	cate be executed by sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underfying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence of): Due to (or as a consequence of):			
O. Box 68	ath certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 3 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cont	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Onknown
Vital Reco	in: The law r ificate has be or, page 2 sh	e Completed	25. Was case referred to medical		26 Place of C	24a. Was an autopsy performed 1 Yes 2	
Division of Vi	To the Hospital or Attending Phyalcian: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation; To B	examiner? 1 Yes 2 Ho 27. Manner of Death Actural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing	Home Sidence 28d. Describe how in	
DIVIS	Hospital or Att 24 hours after de Funeral Directs stely filled in by t	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify) ician: To the best of my knowledge, de-		City or Town, St	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the Funeral Direction of the Funer	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier	er: On the basis of examination and/or and manner stated.	29c. License number		Date signed (Month, Day, Year)
	3		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Typ	a, Print)	2064	(6
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 4 200	32. Jegistrar's Signature	berti		

		•	For State Registrar		State	of Mary	land / Depa	artment <i>rtificate</i>			and Me		giene	005		0393
В	hysici	an	1. Decedent's Nam	e (First, Middle	, Last)						1	2. Date of Dea			ear	3. Time of Death
	/Medic	al	Bruce	Owen	Francis							Novemb	er 2	8, 20	005	11:40 A M
Ē	Examir	er	4a. Facility Name (number)		4b. City, To		ocation o	f Death			County of		
Fu	ineral		5. Social Security N	-	6. Sex	7. Age (In	yrs. last birthday)	If Under 1	Year	If Under 2	24 Hrs. 8	B. Date of Birt	h	ontgo		ace (State or Foreign
	rector		510-48-6	5799	1 X M 2□ F	55	Yrs.	Months	Days	Hours	Min.	Month Day	1950	K	Countr	ועו
and	*	}	Usual Residence of 10a. State	f Decedent 10b, County		100	. City, Town or Lo	ocation							10	d 1id- Ob 11 i-ib-
Maryl	f sho	JO.	Maryland		mery		Gaithers								10	d. Inside City Limits 1 Yes 2 No
the	r 28a	Director	10e. Street and Nu	mber				10f. Zip C	code				10g. Citiz	en of Wha	at Countr	
th with	23a o	ai D	6 Rich E	Branch (Court			2	20878	3			Unit	ed S	tate	:S
er dea	tems Lacra	uner	11. Marital Status		Amed	cedent Ever Forces?	in U.S. 13.	Was Deceder	nt of Hisp y Cuban,	anic Orig Mexican,	in? (Spec , Puerto Ri	fy Yes or No- can, etc.)	. 1	4. Race -	America: White, et	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	T, or	by Funeral	1 Never Marr 3 Widowed		ed 1 Tes, If Yes, Year or	s 2 🛣 No Give	1	1 ☐ Yes 2		Specify:			i	Specify:		
2 hou	atura cal E			15. Decedent	's Education		16a. Dece	dent's Usual (Occupation	on			16b. Kin	d of Busin	ness/Indu	ıstrv
215 thin 7	e in	Completed	(Spec		t grade complete	d) (1-4or 5+)	(Give	kind of work DO NOT use	done dur retired)	ring most	of working	'		tric		,
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Menial Hygiene.	f.	Con		-	5		Self-	employ						neer	ing	
Yland 21 Nould be filed wit	ed otl	Be	17. Father's Name Horace H		.ast)						r's Name (. Rick	First, Middle,	Maiden S	Sumame)		
aryla should and Men	mark matic	၉	19a. Informant's N		ip (Type, Print)		19h Mailir	ng Address /9				Route Numbe	r City or	Tour Sta	to Zin C	2ada)
and 2 seatth ar	27 Is r trau		Nancy Lo			(Wife)						therst				
Baltimore, sermit. Pages 1 ar	Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Exuminar must be notified at a case.		20a. Method of Dis	position		20	b. Place of Dispo	sition (Name	of		Dat	e		ation - Cit		
Pages ment of	LIZ OF		`4 □Donation		3 □Removal fro pecify)		[etropoli	itan Cı	rem.	2	Dec. 2005	100	Alexa	andri	a, V	/a.
Balt permit. Departr	nport ny inj		21 Syna ure of Fu	ineral Service L	iceosee	e. 0 (1 Fune	ral	Home		
	_ 0 9		220 Part Enter	the disease of	VIII								_	burg		. 20877
			23a. Part1. Enter to shock, or hea Immediate Cause	it lallure. List o	only one cause or	each line.	death. Do not ent	er the mode of	of dying,	such as c	ardiac or i	espiratory arr	rest,		lr lr	Approximate nterval Between Onset and Death
, .	ician dical		disease or condition resulting in death)		a. AC		PULMON	ARY	Er	BOL	151					Z HRS
	niner				Due	o (or as a con	isequence of):									
73	-	ner	Sequentially list co if any, leading to im cause. Enter Unde	nditions, nmediate eriving	b. — Due t	o (or as a con	sequence of):									
ecuted	transi	Examiner	that initiated events resulting in death) i	iffjuly	c											
8 760, cate be executed	sician and burial-transit		rosaning in doamy	cu3t	Due t	o (or as a con	sequence of):									
cate cate	the	edical	_		d										-	
the death certification	attending	lan/Me	IF FEMALE: 23b. Was deceden	t pregnant		utcome of pre							23	3d. Date of	delivery	
death death	ed for	icla	in the past 12 1 Yes 2	months? ZNo	4□Pre	birth 2 🗌 F gnant at time]Ectopic preg] Other (s <i>pec</i> :					-	Month		ay Year
at the	detached f	Physic	9 🗌 Unknown		9□ Unl											
ecords, Palaw requires that	5 6	by	Part II. Other signif		_		resulting in the ur	nderlying cau:	se given i	in Part I.		_				cause of death?
nbee.	should I	eted	TRIPINKY	BRA	IN TUM							1 🗆 Yı		No 3] Probab	oly 4 Dunknown
0 9	nas 192	ompieted										24a. Was a autops perforr	sy	24b. Were prior deat	to comp	y findings available letion of cause of
_ F		O.	25. Was case refer	red to medical						0.00	(5)	1 ☐ Yes	2.2 No		Yes 2[□ No
	2 등	0	examiner?		Hospital:	Inpatient 2	2 Z ER/Outpatien	t 3 DOA				Check only on 5 🗌 Reside		Other (Speciful	
n OT ng Phys	tuneral	T inc	27. Manner of Deatl	h 5 🗌 Pending	28a. Dat	e of Injury onth, Day Year	28b. Time of		. Injury at Work?		280	d. Describe ho	ow injury	Derruppo Derruppo	specify)	
SIOI tendii leath.	the tu	catic	2 Accident	investiga	ation		,,,	М		s 2 N	0					
al or Attending F s after death.	in by	ertification;	3 ☐ Suicide 4 ☐ Homicide	determin	ned 286. Plai	e of Injury - A ding, etc. (Sp.	At home, farm, stre ecify)	et, factory, o	office		28f	Location (St City or Town	reet and i n, State)	Number o	r Rural R	Route Number,
Spital	completely filled in by	O	29a. Certifier	1 Certifying	Physician: To the	ne hest of my	knowledge, death	Occurred at t	the time	data and	place enc	I due to the e				
B Ho	letely	edical		2 Medical E	xaminer: On the	basis of exam nner stated.	ination and/or inv	estigation, in	my opini	ion, death	occurred	at the time, d	ate and p	lace, and	due to th	e cause(s)
To the Hospital or A within 24 hours after To the Euneral Direct	comp		29b. Signature and	title of certifier				29c. L	icense nu	umber		2	9d. Date	signed (M	onth, Da	y, Year)
	0		Ma	wym	young			D	2330	8		N	ovem	ber 2	29, 2	2005
('			30. Name and addre							11.1.1.0	0 -			0.00	_	
	Sta		Victor M. 31. Date filed (Month			4			ve,	#4100	u, Be	thesda	, MD	2081	. /	
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			1 - For State Registrar	State	of Ma	ryland /	-	artment of H		nd Mer	•	giene Reg. No.	005	403	394
Ä	Physicia	an	1. Decedent's Name (First, Middle	e, Last)							Date of De Month	Dav	Year		e of Death
	/Medic	al	CHARLES		VARD)	FOW		-1		OVEME				40 A M
	Examin	er	4a. Facility Name (If not institution MARYLAND HOUSE	•		N		JESSUP	r Location of L	Death			County of Dea		n
	Funeral	-	5. Social Security Number	6. Sex		(In yrs. last	birthday)	If Under 1 Year	If Under 24		Date of Bir	th	9. Bi	rthplace (Sta	te or Foreign
	Director		213-84-8249	1∭M 2□F	3	4	Yrs.	Months Days	Hours	Min. A	(Month, Da ug 15	19	71 Ma	rylanc	1
	pue *		Usual Residence of Decedent 10a. State 10b. County			10c. City, To	own or Lo	ecation						10d. Inside	e City Limits
	Maryline f	jo	MD Anne	Arundel			West	River							es 2∑No
	r 28a	Director	10e. Street and Number					10f. Zip Code				10g. Citiz	en of What C	ountry?	
	th with	al D	1130 Cherry P	oint Roa	đ				20778	3			USA		
	tems tems	Funeral	11. Marital Status	12. Was De Armed	Forces?		13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	n? (Specify Puerto Rica	Yes or No in, etc.))- 1	4 Race - Am Black, Wh		1,
5	rs afte	by F	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes (Sive No.	0		1 ☐ Yes 2 💆 No	Specify:				Specify: w	nite	
2-003p	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or items 23a or 28s-f show event, the Madical Examinal must be notified at		15. Deceden	nt's Education		16	6a. Dece	dent's Usual Occup	ation			16b. Kin	d of Busines:		
7	thin 7	Completed	(Specify only highe Elementary/Secondary (0·12)	1	(1-4or 5-	+)	life.	kind of work done of DO NOT use retired	during most of d)	i working					
7	filed wi Hygien Sther th		12 17. Father's Name (First, Middle,	(ant)			car	penter	18. Mother's	Nome /C	est Middle		onstru	ction	
/land	d be fi	Be	Coolidge Ler		ler,	Sr			Margi		rsi, middie, Lee	Hall			
_	2 should to and Meni is marked	To	19a. Informant's Name/Relations	-	101 /		9b. Mailir	ng Address (Street						Zip Code)	
Z			Coolidge L. Fo	wler, Sr	., fa			-							
ē.	of Hear		20a. Method of Disposition			20b. Place	of Dispo	sition (Name of natory or other place		Date			ation - City o		
Ē	Page ment ant: h		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (S		n State	Metro	opoli	itan Crem	atory	11/29	/05	Ale	xandri	a, VA	
gair	permit. Pages 1 and Depertment of Health Important: If item 2: eny injury or other 1		21. Signature of Funeral Service	Licensee				2. Name and Addre							
_	40200		23a. Part1. Enter the disease, or	r complications tha	r caused	the death D		Rausch Fu					ings,	MD 20 / Approxir	
	Dharisina		shock, or heart failure. List Immediate Cause (Final	only one cause or	each line	е.	o not on	or the mode of dyn	.g, 546 45 64		opiratory a	11001,		Interval	Between nd Death
	Physician /Medical		disease or condition resulting in death)	a	olorasa	consequence	ce of):								
	Examiner		Constant by the constitutions	,	. (,-								
	₽ #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying	Due t	o (or as a	consequence	ce of):								
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	o for as a	consequenc	ce of):								
g / 60,	sician buria														
200	ificate g phys as the	edical		0.											
X Q Q	death certif e attending id for use as	Ician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o		of pregnancy 2 Petal dea		Ectopic pregnancy	,			2:	3d. Date of de		
		slcis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at t	time of death		Other (specify)					Month	Day	Year
r S	law requires that the as been signed by th 2 should be detache	Physl	Part II. Other significant conditi	ons contributing to	death bu	t not resulting	a in the u	nderlying cause giv	en in Part I		23e Did t	obacco us	e contribute i	o the cause	of death?
ecords,	signe d be	d by	, <u></u> ,		004.11.00		9 11 11 10 0	ndonying oddoo giv	on arr arr.			Yes 20		robably 4	
S	w req	Completed									24a. Was	an	24b. Were a	utoosy findin	os available
r	0 5 0	E O								-	autor		prior to death?	completion of a completion of	
VITAI	ifcien: Th certificete rector, pag	BeC	25. Was case referred to medica examiner?	1		.7			26. Place of				1 100 10	2 2 140	
_	şe sici	To	1 X Yes 2 No		Inpatier				er: 4 ☐ Nursi					ocity) SCE	NE
<u></u>	ding Phy th. : After thi funeral	lon:	27. Manner of Death 1 □Natural 5 □ Pendir	ng (Mo	e of Injury onth, Day	Year)	b. Time of Injury	Wor	yat k? Yes 2∭(No	i	Describe 1		-yed h	2 014	
DIVISION	death death ctor: y the	flcat	2 Accident investi	not be	ce of Inju		farm, str	A		28f	Location /	Street and	Number or F	ural Route N	lumber :
2	s effer if Dire	Certification:	4 Homicide			(Specify)		eet, factory, office			City or Tox	wn, State)	Maryland Jessup	House of	Collection
	To the Hospital or Attending Pl within 24 hours effer death. To the Funerel Director: After the completely filled in by the funera	cal		ng Physician: To t Examiner: On the	he best o	f my knowled	dge, death	occurred at the tin				cause(s) a	and manner a	s stated.	vo(s)
	the H hin 24 the F	Medical	one) A	and ma	anner stat	ted.	and or in								
	o viji vije	_	29b. Signature and title of certifie	mid				29c. Licenso	C M E				signed (Mon IBER 25		
•			30. Name and address of person		use of do	ath (Itam 22	a) (Tune	Print)							
	5		LING LI	MID COMPLETED CO		(nom 20	11	1 PENN S	TREET,	BALT	IMORE	, MAF	RYLAND,	2120	1
	Sta		31. Date filed (Month, Day, Year,	32.	Registra	s Signature	Lo	1.00							
	Registr	ar	NU	2 9 2005	7	CALLES.	J.G.	Sperie							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Year WILLIAM JOHN FARRELL DECEMBER 8 2005 /Medical 1:37 Р 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y March 4, Birthplace (State or Foreign Country) Days Hours Months 156-05-5794 1**X** M 2 ☐ F 82 Director Yrs 1923 New Jersey Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov ral', or itema 23a or 28a-f ehov Exercit at must be notified at Maryland Frederick Walkersville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 323 Silver Crest Drive 21793 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No WW II Yes or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ Specify. SpeciWhite 3 ☐ Widowed 4 ☐ Divorced "natural", Completed marked other than "naturalization matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Specialist Telephone Company traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental John Farrell Mary McNicholas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mrs. Marguerite Farrell, wife 323 Silver Crest Dr., Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify Entonoment Ocean County Mem. Park Dec. 12, 2005 Tams River, NJ 21. Signature of Furneral Service Licenses ² Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 awc 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Neumonia irati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death P.O. I ed by the a 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 ØUnknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes 2 No 1 Tyes funeral director. 25. Was case referred to medical Be 26. Place of Death Check only one 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Wo December 9, 2005 use of death (Item 23a) (Type, Print) 30. Name and address of person who completed 56 homas toward 31. Date filed (Month, Day, Year) ្ល32. Registrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene = For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gilbert **Physician** Month a.k.a. Charles Morris December 2005 5:22p M Charles Maurice Gilbert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Apr 8, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 12 M 2□F 72 Director 217-28-1102 Mary Land Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov other traumatic event, the Medical Examiner must be rightlied at Director Maryland Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1900 Rosemont Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if flem 27 le marked other than "nature" once, injury or other traumatic acceptance. 21702 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 XDivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Stone Products Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gilbert Charles Mae White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 East "E" Street, Brunswick, Maryland 21716 Carol A. Burris / Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem Gardens Dec 10,2005 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church St, Frederick, Maryland 21701

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate
Immediate Cause (Final Approximate Interval Between Vollacrela Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): o the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2X No Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has le 2 s certificate ha 1 Yes 1 Tyes director. 25. Was case referred to medical Be 26. Place of Death (Check only one, 1 Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide within 24 hours after d To the Funerat Direct completely filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a 30. Name and address of person who completed, ause of death (Item 23a) (Type, Print) Robert L. Kaufmann, 300 West Ninth Street, Frederick, Maryland 21701 MD. 31. Date filed (Month, Day, Year) DEC I 4 32. Esgistrar's Signature State Registrar

	Physici /Medic Examin Funeral Director
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat", or iteme 23s or 28s-f show eny injury or other treumatic event, the Medical Examination must be notified at once.
	No.
j g	Physician /Medical Examiner
	and and al-transit

<u></u>		1 - State Registrar Amended #	23b per MD			rtificate of			Reg. No	0.05	40397
Physici /Medic	al	Decedent's Name (First, Middle, Thelma Louise 4a. Facility Name (If not institution,	Gillespie	3		4b. City, Town, o	or Location of De	Month	ber 2		5 3101 PM
Examin	er	Union Memorial		,		Baltimo		Balli	1	None	eau
Funeral				ge (In yrs.	last birthday		If Under 24 h	lin. (Month,	Day, Year,	9.	Birthplace (State or Foreign Country)
Director		229-56-7541 Usual Residence of Decedent	10 W 2001	62	Yrs.			April	15,1	943 V	irginia
show		10a. State 10b. County		10c. Ci	ity, Town or L	ocation					10d. fnside City Limits
Ba-fa	ctor	Maryland Freder	ick	Ija	msvill	1					1 ☐ Yes 2√€ No
with the M is or 28s-f Les notifie	Funeral Director	10e. Street and Number 9611 Reichford F) ₄			10f. Zip Code 21754				tizen of What ted St	•
death w me 23a cmust t	nera	11. Marital Status	12. Was Decedent		J.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or			mencan Indian,
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or iteme 23s or 28s-f show event, the Madical Examirar must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced				1 ☐ Yes 2 ☑ No		Jorio Fricari, 610.)		Specify: V	
"naturat",	Completed	15. Decedent's (Specify only highest			16a. Dece	edent's Usual Occup s kind of work done DO NOT use retire	oation during most of	working	16b. F	(ind of Busine	ss/Industry
d 2 should be filed within h and Mental Hygiene. 7 le marked other than "treumatic event, the Mental treumatic event.	dwc	Elementary/Secondary (0-12)	Coflege (1-4or	5+)	Real		a)		Rea	1 Esta	te
- 0 - 5	0	17. Father's Name (First, Middle, La	ast)		1		18. Mother's I	Name (First, Mide	dle, Maider	1 Sumame)	
Menta Menta Arked atlc	To B	Unknown					Franc	is Stow	ers		
12 shound 1 lend		19a. Informant's Name/Relationshi Tony Gillespie/				ing Address (Street					a, Zip Code)
1 and Healt Iem 2 other		20a. Method of Disposition	3011	20b. I	Place of Disp	Hines Rd		Date Date			or Town, State
Pages ent of nt: If I		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9		matory or other place. Cremator	111	/29/2005	Fred	erick,	Maryland
permit. Pages 1 and 2 should by Department of Health and Mental Important: If Item 27 le marked eny injury or other treumatic engine.		21. Signature of Funeral Service Vi	centee		2	2. Name and Addre	ss of Facility	Stauffer Pike, Fr	Fune ederi	ral Ho ck, MD	me, P.A. 21702
N		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the dea	th. Do not en	ter the mode of dyir	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between
Physician		fmmediate Cause (Final disease or condition				shoc					Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	s a conseq				ation			06) 6
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consec		Pulmonar	y aspir	acton			20 ms
cuted	Examiner	that initiated events	c								
cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or a	a consec	quence of):						
rtificate b	Medical		d								-
eath certifi attending for use as		fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7				23d. Date of	delivery
the death ce	Physician/	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			□Ectopic pregnancy □ Other (specify) _	y 		-	Month	Day Year
es that the de igned by the be detached	by Ph	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	underlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute	to the cause of death?
w require been sig should b				.				_ 1[]Yes 2	2 No 3□	Probabły 4 ☐Unknown
e lawr has be je 2 sh	Completed							24a. W	topsy	24b. Were	autopsy findings available o completion of cause of
yeicien: The is certificate hidirector, page								Ye.		death 1 🗆 Y	
eicier certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: Inpat	ient 2	ER/Outpatie	nt 3 DOA Oth		Death <i>(Check onl</i> g Home 5 ☐ Re		€ □Othor (S	posifu)
ig Phy ter this	-	27. Manner of Death	28a. Date of fnj		28b. Time o			28d. Describ			oecny,
Attending or death. octor: After by the fune	catio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ition		,,		Yes 2□No				
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could no 4 Homicide determin				reet, factory, office			(Street ar Fown, State		Rural Route Number,
To the Hospital or within 24 hours afte to the Funeral Director completely filled in	Medical	29a. Certifier (Check only one) Certifying 2 Medicaf E	Physician: To the bes xaminer: On the basis and manner s	of examina	owledge, dea ation and/or in	th occurred at the til nvestigation, in my o	me, date and pla ppinion, death or	ace, and due to the courred at the time	ne cause(s e, date an) and manner d place, and c	as stated. lue to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	1 . 1 .			29c. Licens		11 -			onth, Day, Year)
		Milling	Lousy	me)	ATA		\mathcal{O}	NO	rembe	, २५, २००
10		Angela Misic	TUSKY QC				PKWY	Baltim	ore.	mo	वावाष्ठ
Sta		31. Date filed (Month, Day, Year)	32. Reg	ar's Signa	ature 🚣	Aparle			•		
Registr	ar	DEC 0	1 2005	The same	D	your					

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		artment of rtificate o			iene 2.005	40398
	Physici	an	Decedent's Name (First, Middle, Last Ruth Ann GRUBB	st)				2. Date of Dea Month	Day	3. Time of Death
100	/Medic Examir	cal	4a. Facility Name (If not institution, give	a street and number)		4b City Town	n, or Location of De	November	4c. County of	
1	Examir	ier	Washington Count				erstown	54.11		ashington
1,	Funeral	12/32	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Ye Months Day	ar If Under 24 l	Irs. 8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		218-30-4963	□M 2QxF	55 Yrs.		110013	July 23	,1950	Oregon
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	W. Va. Berke	ley	Fallin	g Water	s			1 ☐ Yes 2 No
	ith the	Jirec	10e. Street and Number			10f. Zip Cod	9	1	0g. Citizen of Wh	nat Country?
	ath w	rai	21 Mercer Lane			254			USA	
21215-0036	be illed within 72 hours after death with the Maryland ital Hygiene. I hatural', or Iteme 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ 1		(Specify Yes or No- lerto Rican, etc.)	Black.	- American Indian, White, etc. white
2-0	72 ho	Completed	15. Decedent's Ec (Specify only highest gra	lucation	16a. Dece	dent's Usual Occ	cupation	working.	16b. Kind of Busi	iness/Industry
21	within ane.	nple	Elementary/Secondary (0-12)	College_(1-4or 5+)		_	ne during most of i ired)	working	1	1
12	e filad w Il Hygiai other ti vent, Illi		11 17. Father's Name (First, Middle, Last)	0	no	memaker	19 Mothodo I	Name (First, Middle, M		n home
Maryland	Mental Parked of	To Be	Robert M. William					ame (First, Middle, R Luana Ric		
ary	S D E E	F	19a. Informant's Name/Relationship (19b. Mailii	ng Address (Stre		Rural Route Number,		tate, Zip Code)
	is 1 and 2 of Health a Item 27 is other tran		Gary Wayne Grubb			CONTRACTOR OF THE PARTY OF THE		lgesville,	W. Va.	25427
ore	gas 1 av t of Haa if Item or othe	ľ	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	Ob. Place of Dispo cemetery, crei	sition (Name of natory or other p	place)	Date	20c. Location - C	ity or Town, State
altimore,	t. Pag timent rtant:		4 □Donation 5 □ Other (Specify)			Park 12			wn, Maryland
Bal	permit. Pagas 1 Dapartmant of H Important: if Ite eny injury or ot once.		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or com	11/1/ke	my 4		lson Blvd	MINNICH ., Hagers	own, Md	
8760,	Physician /Medical Examiner superprise physicien and bhysicien and superprise superprise physicien and superprise physicien and superprise physician superpr	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	nsequence of):	uom	Oligod	lindrogl	10mes	Interval Between Onset and Death (2 June)
P.O. Box 6	The law requires that the death certificate be axecuted to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal déath 3	Ectopic pregnar			23d. Date of Month	
	ras that ignad b be data	by Pt	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause	given in Part I.	23e. Did tob	acco use contribi	ute to the cause of death?
ğ	w raquire baan sig should b							1 □ Ye	s 2 □ No 3	Probably Unknown
Division of Vital Records,	hysician: Tha law r his cartificata has ba I diractor, paga 2 sh	Completed						24a. Was ar autopsy perform 1 Yes 2	ed? dea	re autopsy findings available or to completion of cause of the? Yes
Z	siciar cartif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	o□50/0 · ·) · · · · ·	leath Check only one		
o	Attanding Physician: r daath. sctor: Aftar this cartifice by the funaral director, g	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of	28c. In	4 🗀 1401 211 (Home 5 Reside		(Specify)
ö	ath. pr: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Ir) Injury		/ork? ☐ Yes 2 ☐ No			
Divis	s after da s Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, str pecify)	eet, factory, offic	ө	28f. Location (Str City or Town,	eet and Number State)	or Rural Route Number,
	To the Hospital or Attanding Phys within 24 hours after daath. To the Funaral Director: Attar this complataly fillad in by the funaral di	edicai	29a. Certifier 1 / Certifying Ph	vsician: To the best of my irrer: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at the restigation, in my	time, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and mann- te and place, and	er as stated. I due to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	Migd		29c. Lice	nse number	29	d. Date signed (/	Month, Day, Year)
			manyar J	and p		1128	365	(6	1-1-05	
H	-i0		30. Name and address of person who of MAW2AR.	1-SHAM 3	(Item 23a) (Type. 68 nuu	Print) Stree	1- Hag	13 eistom. M	10211	40
1	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 2 20	32. Funistrar's S	ignature	c de				

			1 - For State Registrar	State of Maryl		ārtment of rtificate o				iene	5 1	03	99
	Physici /Medi	cal	Decedent's Name (First, Middle, Lass	enia Geppi		4b. City, Town	or Location		2. Date of Death Month NOV .	2 ^{Day}	Year 2005 ty of Death	3. Time 8:10	
	Examir Funeral	ner	10117 Keyser Poin 5. Social Security Number 6. Se	t Rd.	rs. last birthday)		n City		8. Date of Birth (Month, Day,	Worc	ester	lace (State	or Foreign
	Director		215-28-6611 Usual Residence of Decedent 10a. State 10b. County	□M 2X□F 74	Yrs.		7 110013		Feb. 1,	1931	1931 MD 10d. Inside City Limits		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 ahow or other traumatic event. The Modical Exertitue rotat be notified at	by Funeral Director	MD Worceste 10e. Street and Number 6 Royal Oaks Dr. 11. Marital Status	12. Was Decedent Ever in Armed Forces?	Ocean	Pines 10f. Zip Code 2181 Was Decedent of Yes, specify Code	11	rigin? (Spe n, Puerto l			What Cour	itry?	es 2X No
21215-0036	2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked other than "natural", or items 23a raumatic event. The Worleal Examination until	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edd (Specify only highest grace Elementary/Secondary (0-12)	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Judation de completed) College (1-4or 5+)	16a. Dece (Give life.	1 ☐ Yes 2 ☒ N dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during mos ired)	st of worki	ng 1	16b. Kind of			
Maryland 21	should be filed with and Mental Hygiene. s markad other than umatic event. The M	To Be Cor	17. Father's Name (First, Middle, Last) August Flavian Zo			oaper Di	18. Moth	er's Name nna D	(First, Middle, M	faiden Suma			
Baltimore, Mar	permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or othar traun ang.e.		19a. Informant's Name/Relationship (T) Frank J. Geppi 20a. Method of Disposition 1 Burial 2 [X Cremation 3] 4 Donation 5 Other (Specify) 21. Signature if Juneral Avvice Licens	Removal from State C	6 Roy cemetery, crer ape Hen	yal Oaks sition (Name of natory or other p lopen Cr Name and Add	olace) rem.	Ocea 12-2 The	n Pines, ate 2 -2005 F Burbage rlin, Md	Md. 2 oc. Location rankfo Fune	21811 -City or To ord, De ral Ho	wn, State Lawar	^e
8760,	Cate be executed hybrician and physician and Examiner the burial-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) S. Quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a const.) Due to (or as a const.) Due to (or as a const.)	eath. Do not ent	er the mode of d	lying, such as	cardiac o		st,		Approxima Interval Be Onset and	etween
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<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause o	given in Part I		23e. Did toba	3		e cause of a	
Vital Records,		e Completed	25. Was case referred to medical				26 Place	of Dooth	24a. Was an autopsy perform 1 Yes 2 Check onlone	ed? ZNo	Were autop prior to con death? 1 Yes	esy findings apletion of c	available cause of
of	or Attending Phatter death. Diractor: After thin by the funeral	Certification: To B	examiner? 1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year, 28e. Place of Injury - Abuilding, etc. (Spe	t home, farm, stre	28c. Inj W M 1[Other: 4 Nu jury at fork? Yes 2	rsing Hom 2 No	ne 5 Residen 8d. Describe how 8f. Location (Stre City or Town,	oce 6 X Other		Assis Livi	ted ng
_	Hospital 4 hours Funeral	edical	one) 2 Medicel Exami	sician: To the best of my k ner: On the basis of exam and manner stated.	knowledge, death	occurred at the restigation, in my	time, date an opinion, dea	d place, a	nd due to the cau d at the time, dat	use(s) and m e and place,	anner as sta and due to	ited. the cause(s	s)
	To the within 2 To the Complet	M	29b. Signature and title of certifier		lem 00-1 57	03	nse number	7		d. Date signe	30/05		
	// Sta -Registr	- ·	30. Name a d ≠ dress of person who d 31. Date filed (Month, Day, Year)	ompleted cause of death (I	mon		13007	Coast	tal Hwy.	0.C,	MD 21	842	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 7 Year GIBSON 0412 AM FLOYD AUGUSTUS 4a. Facility Name (If not institution, give areet and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore City
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. The Johns Hopkins 5. Social Security Number 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 219-34-7515 67 March 8, 1938 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16905 AlCott Road 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) 10 Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank T. Gibson Mary E. Preflatish 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loise Gibson (Wife) 16905 Alcott Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State December 8, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 2005 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Mome MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Pavis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS15 Iwalk Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? lying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? large bowel obstruction 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

and

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

ir than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: if item 27 is marked other then "naturel", or Iteme 23

other treumatic event,

5

permit. Page Department of Important: if any injury or once.

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical signed by the atte d be detached for should b Be Certification: To To the Funerei Director: After the completely filled in by the funeral Medical

or Attending Physician: The law requires that the death certificate be executed

this

death.

To the Hospitel within 24 hours a

Box 68760,

Division of Vital Records, P.O.

Part II. Other significant conditions contributing to death but not resulting in the under
Hypartension
Cerebrovascular disease

	24a. Wa auto pen	s an opsy formed?
	1 Yes	20
ath (C	hack only	anal

26. Place of Deat Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient

	peri	ormed?	
10	Yes	2 2 No	
h (Check	only	опе)	

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation

3 DOA 28a. Date of Injury (Month, Day Year) 2Bb. Time of 28c. Injury at Work? М 1 Tes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 Suicide 6 Could not be determined 2Be. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2 Accident

29a Certifier

Cristine

29c. License number RES-000

29d. Date signed (Month, Dey, Year) December 7, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THE JOHNS HOPKINS HOSPITAL GOON. WOLFESTEBET BAUTMORE, MARYLAND BERRY CRISTINE 31. Date filed (Month, Day, Year) DEC 1 4 2005

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 15 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dec 7, 2005 Vear **Physician** Hall 11:50 pm Frances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 27, 1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🖫 F MD 92 Yrs 215-34-4705 Director Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28e-1 show the Medical Examinat must be notified at Cumberland MD Allegany 1 □ Yes 2 □ No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 512 Winifred Road 21502 238 USA death Completed by Funeral items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status illed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Specify: white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Year or Dates: "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide Nursing Home treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laura (none) Fletcher Howard Fletcher 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any Injury or other treun 9002. Mildred Dixon daughter 12903 Silverspring Drive Little Orleans MD 21766 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glendale Cemetery 12/12/2005 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Discare Physician Vs Oronana disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of) Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ page 2 should be 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2∏ No 20 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To in by the funeral 27. Manner of Death

1 Natural
2 Accident 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide filled 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai within 24 ho To the Fun completely f To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 D0033282 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue Cumberland MD 21502 Sunil Gupta M.D. State Registrar

ORIGINAL

			State of Maryland / Dep 1- State amended #26 per MD; fchd Co	partment of Health and Nertificate of Death tml2	/1/05	iene 2005	1.01.02
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physici /Medic		Mary Elizabeth Higgins		Month Novembe	r 23 200	ar
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D	
		u	11301 Youngstoun Drive	Hagerstown		Washin	igton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		Month, Day, August 3	, 1935	Iowa
	land		10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
	Many f sh	ō	Pennsyl- vania Franklin Wayne	horo			1 X Yes 2 □ No
	r 28a	Director	vania Franklin Wayne: 10e. Street and Number	10f. Zip Code	16	g. Citizen of What	
	n with		300 W. Fourth Street	17268		United	,
	deat	Funeral		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		merican Indian,
9	atter or ite	F	1 Never Married 2 Married I Yes, Sive	-	Rican, etc.)	Black, W	
8	hours atter death with the Maryland tural, or Items 23a or 28a-f show al Examiner must be mulfilled at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 ፟ No Specify:		Specify:	White
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Maryland 21215-0036	0 0 0 D	m	Earl Raymond Jeffers			•	
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Baltimore,	pernit. Pages 1 an Depirtment of Heal Important: If item 2 any njury or other once.					neral Hor	
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ı			23a. Part1. Enter the disease or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	1 (chamic			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1 (Schame			Moure
Ø.	Lxammer	_	Sequentially list conditions, b. Metastatic	UTORY Cane	er		Moreva
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
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Box	eath certiti attending tor use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of d	olison
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ec	e law r has be	ompieted			24a. Was an autopsy	24b. Were a	autopsy findings available
<u> </u>		Con			performe	d? death?	
Vita	E E	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
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Division of	ding I. After funer	ion	27. Manner of Death 1	Work?	8d. Describe how	injury occurred	
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	ne Ho ne Fu ne Fu	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Mon	ith, Day, Year)
1			A-C. HEGHZI, MA	D44184		11-25	-05
-	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) - / 1. 2 217.7) n -	1100:0	9
			46 B Thomas Johnson Dr Fr	29c. License number D44184 Print) Lectric M02170	- 1+ 2	MEGA	h
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Registrar

			for State Registrar	State of N	Marylan	id / Depa	artment rtificate	of He	alth and eath	d Mer		ene	105	4040)5
			1. Decedent's Name (First, Middle,	Last)							Date of Death	1		3. Time of	Death
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	Examin		4a. Facility Name (If not institution,	give street and numbe	or)		4b. City, To	wn, or Lo	ocation of De			1	County of Death		
-86			Doctors Communi				Lanh						rince Ge	orges	
	Funeral		,	6. Sex 7. A 1 □ MM 2 □ F	Age (In yrs. 72	last birthday)	If Under 1 Months [f Under 24 H Hours Mi	in.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or ntry)	r Foreign
k	Director		172-26-2491 Usual Residence of Decedent		12	Yrs.				Ma	arch 17	7,]	1933 PA		
	and ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	v Limits
	Mary	tor	MD Prince	Georges		Bowie								1 [X]Yes	
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	deati	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.	.S. 13.	Was Deceder		anic Origin?	(Specify	Yes or No-		14. Race - Ameri		
o	after or its		1 ☐ Never Married 2 X Marrie	1437 01	No		-			erto Rica	an, etc.)		Black, White,	etc.	
213-0030	irai',	d by	3 Widowed 4 Divorced	Year or Dates	· '50 -	'55	1∐Yes 2X	1 NO 3	Specify:				Specify: Wh	ite	
ה	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual (kind of work	done duri	n ing most of w	vorking	11	6b. Kir	nd of Business/In	dustry	
7	within ne. then	шp	Elementary/Secondary (0-12)	College (1-4or	r 5+)		DO NOT use	,							
7	o filed within 72 hours after death with the Maryland tygiene. other than "natural", or iteme 23s or 28s-1 show other than "natural", or iteme 23s or 28s-1 show only. The Marical Examinar must be inclified at		17. Father's Name (First, Middle, La	5+		Nucl	ear Ph			la (F:			Governm	ent	
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ځ	hould d Me mark matic	2	19a. Informant's Name/Relationship			105 14-15-	- Add (C				ella He		ey Town, State, Zip		
	id 2 s ith an 27 is trau		Susanne K. Hill				7 Kee1							Coae)	
บ์	Heal Heal tem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of	n Bow	Date		715	eation - City or To	own State	
2	ages ant of it: If i		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		e Hun	emetery, cren itt Cre	natory or othe matory	r place)	117	/27/			dorf, MD		
allillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Hygiene. Important: If the Z1 is marked other than "natural; or itame Z3a or 28a-1 show any injury or other traumatic event, the Macinal Examinar must be inclified at once.		21. Signature of Funeral Service Lice				-		i :				-		
Ď	Depa impo any ir		1///	2		16	5000 At	nanc	olis R	ober oad	t E. E	van м	s Funera D 20715	al Home	<u> </u>
	*		23a. Part1. Enter the disease, or co	omplications that cause	ed the death								20715	Approximate	
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964	/Medical		disease or condition resulting in death)	a. Acute I			re							1 wee	k
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Ď K	entific ding p	Mec	IF FEMALE:	20. 16								1			
YOU	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregr					23	3d. Date of delive Month	ory Day Ye	921
5	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de	eath 5	Other (speci	fy)					WOTH	Day TE	741
Ľ	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions	s contributing to death	but not resu	ulting in the ur	nderlying caus	e diven i	n Part I		23a Did toba	CCO IIS	e contribute to the	a cause of do	ath?
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2	Attending Ph or death. ector: After th by the funeral	fica	3 ☐ Suicide 6 ☐ Could not	t be 28e. Place of In	njury - At ho	me, farm, stre	eet, factory, of			28f. l	Location (Stree	et and	Number or Rura	l Route Numbe	er
5	al or after Dire	Certification:	4 Homicide determine	building, e	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or Town, .	State)		T TOBIO TABILIDE	<i></i>
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	ai C	29a. Certifier 1 Certifying	Physician: To the best	t of my know	wledge, death	occurred at t	he time, c	date and place	ce, and c	due to the cau	se(s) a	and manner as st	ated.	
	n 24 he Fu yletel	edicai	(Check only 2 Medical Ex	ammer: On the basis of and manner s	of examinati	ion and/or inv	estigation, in	my opinio	on, death occ	curred at	the time, date	and p	place, and due to	the cause(s)	
	To the to the comp	Ž	29b. Signature/and title of contrier				29c. Li	cense nu	ımbər		29d	. Date	signed (Month, I	Dey, Year)	
			1/// /hds/1	1al M			D0	8754			No	oven	mber 25,	2005	
			30. Name and ad ress of person	completed cause of	death (Item	23a) (Type, F	Print)								
			Thomas A. Bensir	- 4			y Cent	er D	r. Sui	ite#:	205 Gre	ent	oelt, MD	20770	0
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2	The second secon	trar's Signat	ure	Lante	D							
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State of Maryland / Department of Health and Mental Hygiene [] [] 5 40406 State Registra AMEND#10e, 19 bperFH, 11/30/05, EMV, McCoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 2005 **Physician** Robert Ν. Hutchison November 1:42 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) Dec. 21, 1932 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12¥M 2□F Months 578-42-7746 72 Yrs Washington, DC Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #515 ŏ 1170 Old Georgetown Road 238 20852 USA Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status be filed within 72 hours after de tal Hygiene. d other then "netural", or Item Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔼 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Financial Advisor Prudential Securities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I tnt: If Item 27 is marked o Harold S. Hutchison Lucile Newman 19a. Informant's Name/Relationship (Type, Print) 1 9b-Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan G. Hutchison/Wife 1179 Old Georgetown Rd., #1515, Rockville, MD. 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Important: If ite any injury or of Dec. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Brentwood, Md. 21. Signature of Funcial Service Licensee 22 Name and Address of Facility De Vol Funeral nome 2222 Wisconsin Ave., NW., Washington, DC 20007 permit. MARC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatic Prostate Cancer Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Year Month Day 5 Other (specify) P.O. I ☐Yes 2☐No detached 9 Unknown The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 3 ☐ Probably 4 🏝 Unknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 X No certificate 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Hospice Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D41218 November 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, M.D., 6001 Muncaster Mill Rd., Rockville, Md. 20855 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 30 2005 Registrar

			State of Maryland / Department of Health and Certificate of Death	d Mental Hyg	iene 2005	1.01.07
			1. Decedent's Name (First, Middle, Last)	2. Date of Deal	eg. No UU)	3. Time of Death
	Physicia /Medic		RICHARD IRVEN HOLDER	DECEMBE	R ³³, 2005	10:00A M
meg.	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De 809 ISRAEL CREEK COURT KNOXVILLE			HINGTON
	Funeral Director		217-12-21/2 124 82 Yrs.	Hrs. 8. Date of Birth (Month, Day) MAR . 8,		Birthplace (State or Foreign Country) IARYLAND
	ow s	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fsh	ctor	MARYLAND WASHINGTON KNOXVILLE			1 □Yes 2√ No
	th with the 23a or 28 Ist be no	Funeral Director	10e. Street and Number 909 ISRAEL CREEK COURT 10f. Zip Code 21758	1	0g. Citizen of What	country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriment runtibe Invilled at Once.	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Marital Status 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pull Yes, Give Year or Dates: 1946	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. WHTTE
Maryland 21215-0036	hin 72 hou s. in "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	working	16b. Kind of Busines	
2	ed with ygiene ner tha it, the	Com	12 CREW CHIEF	Name (First Middle		MANUFACTURER
/land	uld be fil Vental H srked oth	To Be		Name (First, Middle, L. DEENER		
	ind 2 sho alth and I 27 is me or traums		19a. Informant's Name/Relationship (<i>Type, Print</i>) MADELINE A. HOLDER, WIFE 19b. Mailing Address (<i>Street and Number or</i> 909 ISRAEL CREEK COU			
Baltimore,	Pages 1 a ent of Hei nt: If item ry or othe		20a. Method of Disposition 1 Magurial 2 Cremation 3 Removal from State 1 Dopation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) BROWNSVILLE HGTS. CEM 12/		20c. Location - City BROWNSVIL	or Town, State LE, MARYLAND
Balti	permit. Departm Importa any inju		21. Sign fure of Fineral Service Licer ee Paul M. Dean BAST FUNERAL HON		LD NATION	
			23a. Pant 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	diac or respiratory arr		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			3 year
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<u>,</u>	te be executed ysician and te burlal-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Due to (or as a nonsequence of):			
3760,	ate be a nysicial	cai	d			
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of o	delivery Day Year
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Vital Records,	0 - 9	Completed		24a. Was a autops perform	sy prior t med? death	
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of V	d is	ပို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	ng Home 5 X Resid	ence 6 Other (S	pecify)
On	Jing After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	EGG. Describe to	ow injury occurred	
Division	il or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate and plate of the control of the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the coccurred at the time, o	ause(s) and manner date and place, and c	as stated. lue to the cause(s)
)	To the within 2 To the complex	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
LL	1-15+1		30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) Michael McCorneck 11110 Medical C	6000	H	h. M1
' אכ	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	own / ics	118500	wa III
DH	Regist		31. Date filed (Month, Day, Year) DEC 0 5 2005 32. Registrar's Signature A. Aprello			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #31 State of Maryland / Department of Health and Mental Hygiene State Registrar Per DVR WCHD/SH 12/05/05 Certificate of Death Reg. Do. 2. Date of Death 1. Decedent's Name (First, Middle, Last) William

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23e or 28a-4 ehromany injury or other traumatic event, the Madres ...

Funeral Director

Physician /Medical **Examiner**

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JILLIAM

CHANLES

	Charles Willi	am Hutzel	1 1				LAC D SAN	PER 34	2000	833 M
	4a. Facility Name (If not institution,	give street and numb	ber)		4b. City, Town, or	Location of Dear	h	4c. County		
	Washington Cou	nty Hospit	tal			erstown			Washing	
	5. Social Security Number 219-36-3134	6. Sex 7. XXM 2□ F	. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bird (Month, Da April 1	th y, Year) 3,1939	9. Birthpface (Sta Country) Mary I a	ate or Foreigr and
	Usual Residence of Decedent								1	
	10a. State 10b. County		10c. City,	Town or Lo	ecation					de City Limits
Directo	Maryland Wash	ington			Williams	port			10	Yes 2 XNo
5	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?	
	14641 Clear Sp	ring Rd.				21795		USA		
runerai	11. Marital Status	Armed Force		. 13.	Was Decedent of H	ispanic Origin? (S In, Mexican, Puer	Specify Yes or No to Rican, etc.)		ce - American India ck, White, etc.	n,
r y	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf Yes, Give Year or Dat			1 □ Yes 2 🛣 No	Specify:	Specify:			te
	15. Decedent			16a. Deced	dent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry	
5	(Specify only highest	grade completed)		(Giva	kind of work done of DO NOT use retired	during most of wa	rking		,	
Paradillo	Elementary/Secondary (0-12)	Coflege (1-4	40r 5+)	Tru	uck Drive	r		Q	uarry	
	17. Father's Name (First, Middle, L	ast)	,			18. Mother's Na	me (First, Middle,	Maiden Suman	ne)	
	Roscoe Avey	Hutzell, S	Sr.			Esther	Marie	Gosnel		
	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)	
	Ruth Hutzell	- Wife		14641	Clear S	prina Rd	. Willia	msport.	Maryland	2179
	20a. Method of Disposition		cen	ce of Dispo	sition (Name of matory or other place		Date		City or Town, Stat	te
	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			enlawr	n Mem. Pa	rk Dec.	2,2005 W	illiams	port,Mary	land
	21. Signal re of Funeral Service	icephient			SborneddF					
1	1 sin 1.	CA1		42	25 S. Con	ococheag	ue St. W	illiams	port,MD	21795
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State Registrar

32. Segistrar's Signature

			For Stete Registrer	State o	f Marylar		artment of H rtificate of I			giene	005	40409
			Decedent's Name (First, Middle	le, Last)			-		2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		John	Darr	ell		Henderson		December	1,	2005	17:14 M
	Examin		4a. Facility Name (If not institution	n, give street and nur	nber)		4b. City, Town, or	r Location of Dea	th	4c. C	ounty of Death)
			Memorial Ho	spital			Cumberl	land			Allegar	У
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr		h /, Year)	9. Birth Cou	place (State or Foreign intry)
	Director		217-42-6306	1 [X] M 2 □ F	61	Yrs.			02/15/19			y l and
	and w	ł	Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	ty, Town or Lo	eation					10d. Inside City Limits
	/anyl	6	MD All	egany		Cir	mberland					1 ∑Yes 2 No
	the N	Director	10e. Street and Number	Cearry			10f. Zip Code			10a. Citize	en of What Co	untry?
	with Ba or		1001 Yale	Street				.502		-	SA	•
	ns 2;	by Funeral	11. Marital Status		edent Ever in U		Was Oecedent of H	ispanic Origin? (Specify Yes or No-	14	I. Race - Amer	
9	or Ita	교	1 ☐ Never Married 2 🔀 Mar	ned 1 X Yes	2 □ No 196	2-	f Yes, specify Cuba		rto Hican, etc.)		Black, White	, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show he Mydfeol Ever in er must be trofffed at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ates: 196	55	1 ☐ Yes 2 ☒ No	Specify:		S	pecify:	White
5-0	72 honatu	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occupa	durina most of we	orking	16b. Kind	of Business/I	ndustry
21	han ne.	du	Elementary/Secondary (0-12)	College (I-4or 5+)		DO NOT use retired	d) -				
2	fed w fygie fher th		12 17. Father's Name (First, Middle,	(ant)		Own	er	19 Matharia Na	me (First, Middle,		Company	
anc	htal Had of	Be	Charles	Darrell	ı	Henderso			ine (i iisi, iviiddie,	Walden St	Hare	
Maryland	hould d Mei mark metic	ပ္	19a. Informant's Name/Relations		1		ng Address (Street a	Bessie	Tural Boute Numbe	r City or 1		in Code)
Ma	d 2 s th an th an trau		Clementine M. Hende		e		Yale Stree				21502	<i>p</i> 0000)
ē,	Hea Hea tem		20a. Method of Disposition		20b. f	Place of Dispo	sition (Name of matory or other place		Date		ation - City or 1	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any figury or other traumetic event, the Medical Ever the marker collises at ODGe.		1 🖾 Burial 2 🗆 Cremation 4 🗆 Donation5 🗆 Other (5		State		Cemetery	1	5/2005	Cum	herland	Maryland
Ē	artmoortar oortar Injur		21. Signature of Fune al Service		7		2. Name and Address					
ñ	Depar Impor any Ir	l,	1 tiles of	(6	1/1200		404 Decatur			•		•
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that of	aused the deat	th. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final									Onset and Death
	/Medical		disease or condition resulting in death)	a. Car	liac arry (or as a consec	thmia quence of):						minutes
	Examiner		Conventially list conditions	b Cor	nary Art	erv Dise	ease					
	D =	ner	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consec	quence of):						
	acuta and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c	/							
68760,	cate be executed physician and s the burial-transit	dical Examiner	resulting in ocality East	Due to	(or as a consec	quence or):						
87	cate b	dlca		d.								
_	ding p		IF FEMALE:	23c If yes out	tcome of pregn	ancy				00	d Data of dall	
Вох	death certifi e attending I d for use as	slan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	ointh 2 ☐ Feta nant at time of c	al death 3[Ectopic pregnancy Other (specify)	,		23	d. Date of deli- Month	Day Year
o.	the de	ysle	1 □ Yes 2 □ No 9 □ Unkn <i>o</i> wn	9□ Unkn								
Φ.	es that the death igned by the atte be detached for	by Physician/Me	Part II. Other significant conditi	ions contributing to d	eath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	ontribute to	the cause of death?
Records,	requires sen sign nould be								1 🗆 Y	'es 2 🖔	No 3 Pro	bably 4 Unknown
CO		Completed							24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
Re	hyaician: The law his certificate has t I director, page 2 s	omp							autop perfor 1 Tyes	rmed?	death?	ompletion of cause of
Vital	an:] tifical	a	25. Was case referred to medica	al				26. Place of De	eath (Check only o		1 103	2 140
\leq	Phyaician: this certific	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	Inpatient 2 X	ER/Outpatier	nt 3 DOA Oth		Home 5 ☐ Resid		Other (Spec	ify)
Jo L	g P er ti era		27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date	of Injury th, Day Year)	28b. Time o	f 28c. Injun World		28d. Describe h			
Ö	Attending r death. actor: After	atic	2 Accident invest	tigation		,		Yes 2 □ No	44			
Division	r Atto	Certification:	3 Suicide 6 Could 4 Homicide determ	minor 288 Place	of Injury - At hing, etc. (Speci	nome, farm, sti ify)	reet, factory, office		28f. Location (S City or Tow	Street and I m, State)	Number or Ru	ral Route Number,
	ritel o											
	Hosp 14 hou Fune Fune tely fi	edical	(Check only 2 Medice	ing Physician: To the I Exeminar: On the b	asis of examina							
	To the Hospitel or Attendin within 24 hours after death. To the Funeral Diractor: Att completely filled in by the fun	Med	one) 29b. Signature and the of certific		ner stated.		29c. License	e number		29d. Date :	signed (Month	, Day, Year)
			13. 1	no.	Ph.	- >	D544				ber 1, 2	
	5/1UA		30. Name and address of person	who completed cause	se of death (Ite	m 23a) (Type						
	nas			kins, M.D.,			venue, Suit	te 105, Cu	mberland, l	MD 21	502	
	Sta	te	31. Date filed (Month, Day, Year	1 00 6	Laisteada Cian				,			
	Regist	ar	DEC 05	2005	egistrar's sign	I for						

			Please I	ype or Print in							•	
			For	State of Maryla					Mental Hy	giene	Ope I	01.10
			State Registrar		Cei	rtifica	te of l	Death		Reg. No.	000 4	U41U_
JA,	5 %		1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	y Year	3. Time of Death
	Physici /Medic		Ronald	Edward	Hen	sle	У		Novemb	er 2	6, 2005	5:30 p ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of Deat	h	4c.	County of Death	
		Ž,	21 Patuxent Mobil	e Estates			othia			P	nne Arund	del
	Funeral		5. Social Security Number 6. Sec	14 200	. last birthday)	ff Und Month	er 1 Year s Days	If Under 24 Hrs Hours Min.	(Month, Da	v. Year)	9. Birthpla Countr	ice (State or Foreign
	Director		5/9-48-6844	^{1M 2□ F} 71	Yrs.				July 2	8, 1	934 Wash.	, D.C.
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation					100	d. Inside City Limits
	eho e	5	MD Anne Aru		,,		othia	an				1 ☐ Yes 2X No
	Ne N	Director	10e. Street and Number	nder			Zip Code			10° Cit	izen of What Countr	2/2
	72 hours after death with the Maryland natural; or Items 23e or 28e-f ehow dical Examiner must be notified at					101. 2		711		-		y r
	s 23	Funeral	21 Patuxent Mobil	e ESTATES 12. Was Decedent Ever in	116 12	Was Doo	207		Spoody Voc or No		USA 14. Race - America	n Indian
	ltem Item	n.	11. Marital Status 1 Never Married 2 Married	Armed Forces?	0.3.	If Yes, sp	ecify Cuba	in, Mexican, Puer	Specify Yes or No to Rican, etc.)		Black, White, et	
99	rs af	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 X No	Specify:			Specify: while	te
ş	tura stura	ed	15. Decedent's Edu	cation	16a. Dece	dent's Us	sual Occup	ation		16b. Ki	ind of Business/Indu	istry
5	in 72	plet	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of v DO NOT	vork done d use retired	during most of wo 1)	rking			·
212	s within piene. r then "	Completed	8	College (1-401 3+)		pair	nter			Smi	thsonian	Instit.
Maryland 21215-003	filed Hygie other	a a	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden	Sumame)	
<u>a</u>	lid be lenta ked ic ev	0.0	Lawrence	Hens	ley			Myrtle			Stic	ckley
агу	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. I am Americal Hygiene is marked other then "natural; or liems 23a or 28e-f show aumatic event, the Marilial Examiner mult be molified at	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Addre	ss (Street	and Number or Ri	ural Route Numbe	er, City o	r Town, State, Zip C	Code)
	ges 1 and 2 should to f Health and Men i if item 27 ie marke or other traumatic		Linda M. Bayeaux,	daughter	8350) Pus	shaw s	Station :	Rd., Owi	ngs,	MD 20736	5
altimore,	es ta of He of He fitem r othe		20a. Method of Disposition	20b.	Place of Dispo	sition (N	ame of	ea)	Date	20c. Lo	ocation - City or Tow	n, State
Ë	Pages nent of net: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		,	,	atory 11	/30/05	Ale	xandria,	VA
픑	orte orte inju		21 Signature of Funeral Service Licens					ss of Facility			•	
m	Depa Impo eny i		Dura 1 1	ulocel		Raus	ch Fu	neral Ho	me. P.A.	. 0	wings, MD	20736
f o	14 46		23a. Part1. Enter the disease, or complishock, or hearth litture. List only or	tations that caused the dea		1.1					1	Approximate nterval Between
	Physician		Immediate Cause (Final	Atherosch	To	0	-1-		Heat	- 7		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse		-1	10	VASCUIA	0 11 000		3 Care	
	Examiner			·	· ·							
		Je.	if any, leading to immediate	Due to (or as a conse	quence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conse	quence of):							
	0 5 0	cai		ı								
9	The law requires that the death certificate te has been signed by the attending phy: age 2 should be detached for use as the	Physician/Medi										
Вох	h cer endir	N/C	23b. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Tectoric	pregnancy				23d. Date of delivery	
	deat	100	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of 9 Unknown		Other (Month D	Day Year
o.	that the de led by the a detached f	hy	9 Unknown									
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Records,	w require been si should I								1 🗆 1	res 2	□No 3 □ Probal	bly 4 Dunknown
ပ္က	aw re	Completed							24a. Was		24b. Were autops	sy findings available
æ	The law cate has page 2:	E								rmed?	death?	pletion of cause of
Vita		a)	25. Was case referred to medical			777	-0077	26. Place of De	ath Check only o		12103 2	.C. No
<u> </u>	ding Physician: After this certific funeral director,	0 8	examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatier	nt 3 🗆 I	Oth	00			6 ☐Other (Specify)	
0	ding Phys	n:T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f	28c. Injun Worl	y at	28d. Describe l	now injur	y occurred	
0	ndin ath. r: Aft e fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(North, Day 1 dar)	Hijury	M		Yes 2 □No				
Division of	or Attencation death Director:	110	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, fact	ory, office		28f. Location (S City or Tox	Street an	d Number or Rural I	Route Number.
Ö	s after al Dira	Certification:		building, oto. (oppor	,y)				Only or 100	m, olaro	,	
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	al	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my ki	nowledge, deat	h occurre	d at the tin	ne, date and place	e, and due to the	cause(s)	and manner as stal	led.
	he H	edical	one)	ner: On the basis of examinand manner stated.	nation and/or in	vestigati	on, in my o	pinion, death occi	urred at the time,	date and	place, and due to the	ne cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11		2	9c. Licens	e number			te signed (Month, Da	
			Jaradov,	frister DE			Hos	5557	7	Nov	ember 7	29 Zes 5
	,		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print)		^		f		
	6		SALVADOR Sylvate			rine	, ch	ers,	mory la	tod		
(本)	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrates Sign		A	and a	,	,			
			1 1 1 1 1 1			41.5						

			State of Man			lealth and Mental H	•	Jie.
			1- For State State Registrar		rtificate of		Reg. No.	5 40411
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of I	Death Day	3. Time of Death
	/Medic			Insun		12	1 0	5 430 pm
	Examin	er	4a Facility Name (If not institution, give street and number) OKLAND NOTE: PLACE	ofte.	4b. City, Town, o	Location of Death	4c. County	of Death ICH
	Funeral		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8. Date of E Hours Min. (Month,		Birthplace (State or Foreign Country)
	Director		235-22-4734 100 20F	82 Yrs.	Months Days	Hours Min. (Month, 5/26	/1923 E	Brooklyn, NY
	and and		Usual Residence of Decedent 10a, State 10b, County 10	Oc. City, Town or Lo	ocation	-		10d. Inside City Limits
	Many In she	to	WV Preston	Terra A	Alta			1 X Yes 2 ☐ No
	or 28s	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of W	/hat Country?
	ath w	rai	207 Caldwell Street		26764		U.S.	
	item item	Funeral	11. Marital Status 11. Marital Status 12. Was Decedent Eve Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or f In Mexican, Puerto Rican, etc.)	No- 14. Race Black	e - American Indian, k, White, etc.
980	urs af	by	1 Nover Married 2 Married 1 Nover Married 2 Married 1 Nover Married 2 Married 1 Nover Nov		1 ☐ Yes 2 ☑ No	Specify:	Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-1 show is Medical Examinat must be motified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of working f)	16b. Kind of Bus	siness/Industry
7	within ene. than	Jup	Elementary/Secondary (0·12) College (1-4or 5+)		DO NOT use retired Clectric		Ele	ectric
	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		1000110	18. Mother's Name (First, Midd		
/ar	uld be Menta Menta rked rice	To B	Isacc Dayton Johnson			Jennie L. H	eroy Joh	nson
Maryland	2 sho and ls m	(T) 18	19a. Informant's Name/Relationship (Type, Print) Marshall Johnson/Brothe			and Number or Rural Route Num 1 Street, Te:		
	1 and Heelth em 27 ither t			20b. Place of Dispo	sition (Name of	Date	,	City or Town, State
ē	Pages ent of nt: If it ry or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	matory or other place	tery 12/5/05		Alta, WV
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other treumatic event, If a Medical Examinat must be indiffed at once.		21. Signature of Funeral Service License			ss of Facility Wright Fund		
<u> </u>	8 9 5 5 8	(S) (I	23a. Part1. Enter the disease, or complications that ceused the shock, or heart failure. List only one deuse on each line.	1	<u>05 High</u>	land Avenue,	Terra A	Alta, WV 2676
,092	Medical Examiner hysicien and printer ltansit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). The condition of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause).	onsequence of):	bilat	lera		Onset and beath
.O. Box 68	death certific e ettending p id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of properties of the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy		23d. Date Mont	o of delivery th Day Year
S,	es that igned to be det	by P	Part II. Other significant conditions contributing to death but n	ot resulting in the u		0 1		bute to the cause of death?
org	requii	eted	MINEROSCIETOTE CON	onar	y was			3 Probably 4 Unknown
Vital Record	The law requires that the ete has been signed by th page 2 should be detache	Completed	Chronic Scheroph	renca		рег	opsy pr formed? de	fere autopsy findings available for to completion of cause of eath?
<u>ta</u>	ian: T	BeC	25. Was case referred to medical			1 ☐ Yes 26. Place of Death (Check only		Yes 2X No
	Physician: rthis certifice ral director, i	P		2 ER/Outpatien		4 Nursing Home 5 Hes		
U G	ding F h. After funera	tion;	27. Menner of Death 1 Natural 5 Pending (Month, Day Ye	ear) 28b. Time of Injury	Work		how injury occurre	d
Division of	Attanding r death. actor: After by the fune	Certification:	3 Suicide 6 Could not be	At home, farm, str		28f. Location	(Street and Number	r or Rural Route Number,
Ö	tel or rs afte ei Dir	Cert	4 Homicide building, etc. (S	треспу)		City of 16	own, State)	
	To the Hospitel or Attending Phyeicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) Certifying Physician: To the best of m	amination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, and due to the pinion, death occurred at the time	e cause(s) and man	ner as stated. nd due to the cause(s)
	ro the within i	Mec	29b. Signature and title of certifier		29c. License	number	29d. Date signed	(Month, Day, Year)
			1 Sant NO	rlan	04	2464	12/1	105
		Ì	30. Name and address of person who completed dayse of death				11	21550
	C		Sotiere Savopoulos M.D. 31 Date filed (Month, Day, Year) 32 Registrar's	, 2008 I	Maryland	l Highway Sui	te 3, Mt	. Lake Park
	Sta Registr	- 7	DEC - 6 2005	, MA	marke			

		1- State of Mar State of Mar Registrar		artment of Health and N <i>rtificate of Death</i>	lental Hygie.	Z II II II II II	40412
D)		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
Physici /Medi		RUDOLPH S.	JACKS	ON	Nov. 2	0, 2005	11:30PM
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deat	
		4317 Molesworth Terr 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Mt Airy If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frede:	TICK thplace (State or Foreign
Funeral Director		1 □ M 2 □ F	5 Yrs.	Months Days Hours Min.	July 26,	ear) Co	aryland
20		Usual Residence of Decedent					2.
lanylat show	5	10a. State 10b. County 1 MD Frederick	oc. City, Town or Lo Mt A				10d. Inside City Limits 1 X Yes 2 □ No
the M	Director	10e. Street and Number		10f. Zip Code	100	Citîzen of What Co	
3a or	Ö	4317 Molesworth Terr		21771	, , , ,	U.S.A	
death	Funerai	11. Marital Status 12. Was Decedent Even Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
rit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland natural of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or Items 23e or 28e-f show iorinity or other traumatic event, the Medical Event artimative ricitlish and e.e.	by Fu	1 Never Married 2 Married 1 Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ Xio Specify:	ricali, etc.	Black, White Specify: B	lack
72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/	/Industry
within ene. than	impi	Elementary/Secondary (0-12) College (1-4or 5+)		echanic		Priva	ıte
filed Hygir ant, t	ပိ	12th 17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
uld be fental rked (To Be	John Jackson		Flo	rence Cr	oss	
shou and h		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rur		-	
and and malth m 27		Eleanor L. Jackson-Wife	400	Molesworth Te		-	21771
T of its of		143 Buttat 2 Cremation 3 Linemoval non/State		matory`or other place)		Location - City or	
rtmen rtant:		` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Vn Mem Prk $ 11/2 $ 2. Name and Address of Facility $ S $		ckvill	
permit. Pages Department of Important: If i eny injury or once.	4	College K Arole		246 N. Washingt			
		23a. Part1. Enter the dif shee, or complications that caused the shock, or heart falls re. List only one cause on each line.	e death. Do not ent	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	ARDIAL I	SCHEMIA			Onset and Death
/Medical Examiner		Due to (or as a c		LUNG CANCER			
	ē	Sequentially list conditions D.		JONG CANCER			
uted d ansit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
e exection and an arrial-tr		resulting in death) Last Due to (or as a c	consequence of):				
flicate be exacuted physician and as the burial-transit	edicai	d.					
) ± 0.8		IF FEMALE: 23c. If yes, outcome of	oreananou				
eath certifi attending	Physician/M	in the past 12 months?	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli	Day Year
the d by the ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown					
res that the de signed by the a be detached t	by P	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w require been sig should b					1 🗆 Yes	2 No 3 Pr	obably 4XIUnknown
M (7) (1)	Completed				24a. Was an autopsy performed 1 Yes 2 2	prior to d	utopsy findings available completion of cause of
hysician: The It nis certificate ha director, page 2	BeC	25. Was case referred to medical examiner?			h (Check only one)		
hysic this ce	မ	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient					cify)
ling P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Y	(ear) 28b. Time o	Work?	28d. Describe how in	njury occurred	
l or Attanding Phrater death. Diractor: After this in by the funeral.	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, str		28f. Location (Street	and Number or Ru	ıral Route Number.
Ital or A	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)	
To the Hospital or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certifics completely illed in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of or and manner state.	ramination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
To t withi To tll	Ň	29b. Signature and title of certifier A - 2 - 1+664	ZIMV	29c. License number 0 44150		Date signed (Month	
,	H	30. Name and audress of person who completed cause of dea A.Z. Hegazi 46 B Thoma		Print) On Dr Frederick			
St	ate	A.Z. Hegazi 46 B Thoma 31. Date filed (Month, Day, Year) 32 Registrar's	Signature /	J. D. IICGELICK	, 411		
Regist		NOV 3 0 2005	Signature				

			For State Registrar	State of M	larylan			t of H		and M	lental Hyg	giene Reg. No. 1) (1)	Dic.	10110
	Dhyoisi	on	1. Decedent's Name (First, Middle, I	ast)							2. Date of Dea	ith Day	Year	3. Time of Death
	Physici /Medio		Leon David	Kitzm		Jr.					Decembe	r 5, 20	005	2:45 A M
	Examin	ıer	4a. Facility Name (If not institution, g 200 Glades Squar				4b. City,		Location			4c. County		
	Funeral					ast birthday)		1 Year	Oakla If Under	24 Hrs.	8. Date of Birth (Month, Day	n		rett hplace (State or Foreign untry)
	Director		236-58-0934	1귳M 2□F	69	Yrs.	Months	Days	Hours	Min.	Nov. 9.			untry) st Virginia
	p .		Usual Residence of Decedent 10a. State 10b. County		10c Cib	, Town or L	partion							
	faryla r sho	ō			100. 01	, 10w110, E								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-	rect	10e. Street and Number	rrett			10f. Zip	akla:	nd			10g. Citizen of	What Co	untry?
	h with	Funeral Director	200 Glades Squa	re. Apt. 4	£12			2	1550				USA	
	ems :	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Deced			igin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac		rican Indian,
36	s after	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	! 1 ☐ Yes 2 ☐ If Yes, Give] No		1 ☐ Yes				, , , , , , , , , , , , , , , , , , , ,	-	y: Wh	
21215-0036	J within 72 hours after death with the Maryland jiene. The Medical Evaning runt be redilled at the Medical Evaning runt be redilled at	ed b	15. Decedent's	Year or Dates:	60-6		dent's Usua	al Occupa	ation			16b. Kind of B		
215	C 2 00	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give	kind of wo DO NOT u	rk done c	lurina mos	t of work	ing			
21	e filed within Hygiene. other then	Com	12th				Meat	Cut						Store
Ind	0 0 0	Be	17. Father's Name (First, Middle, La	•	_						(First, Middle,	Maiden Suman	ne)	
Maryland	d 2 should be th and Mental 7 Is marked o traumatic eve	2	Leon David 19a. Informant's Name/Relationship	Kitzmi]	ler,		na Address	/Street		thia	I Route Number	r City or Town		sner
Ma	h ar h ar 7 Is rrau		Helen L. Kitzmil								. #12,			
ē,	the sm		20a. Method of Disposition			lace of Dispo	osition (Nar	ne of			Date	20c. Location		
Ē	Pages nent of H ant: If ite ury or of		1 ⊠Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		∍	te Chu	-	-		12/	3/05	Oaklan	d. M	aryland
Baltimore,	permit. Page Department Important; If any injury o		21. Signature of Funeral Service Lic	ensee			2. Name an					2 S. Se		
ш	205 g g	110	Bleaking!	Lling			tewar					akland,	Md.	
	Pnysician	2 10	23a. Part1. Enter the disease, br co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each a Acute	line.		ter the mod	e or dyini	g, such as	cardiac c	r respiratory arr	est,		Approximate Interval Between Onset and Death 3 Mos.
	/Medical Examiner		resulting in death)	Due to (or a										J HOS.
Ь		<u></u>	Sequentially list conditions,	b. Myelof Due to (or a										Years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the arring Cause (Disease or injury that initiated events											
oʻ	exection and and rial-tra		resulting in death) Last	C. Due to (or a	s a consequ	uence of):								
8760,	rate be executed thysician and the burial-transit	ical		d										
39 x	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome	o of around	201							1	*,
Вох	eath certific attending p I for use as	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3[□Ectopic pr □ Other (sp						te of deliventh	very Day Year
o.	it the de by the a tached	nysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	20 01 01	Julii 0 [_ Other (3p							
ď,	res that igned b	by PI	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco use cont	ribute to	the cause of death?
ord	w require been sig should b										1 🗆 Y	es 2 No	3 ☐ Pro	bably 4 Unknown
Records,	e law r has be je 2 sh	Completed									24a. Was a autops	sv i	prior to co	topsy findings available ompletion of cause of
											1 Yes		death?	2 No
Vital	Physician: The this certificate ral director, par	o Be	25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital: 1 ☐ Inpat	iont 2□	ER/Outpatie	nt 3□ DC	Othe			ne Reside			w.,
	g Physical dispersal di	H .	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o		8c. Injury Work	at		28d. Describe h			ity)
ion		atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	ay rear	Injury	М		r Yes 2 □	No				
Division	or Att	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of it	njury - At ho etc. <i>(Specif</i> y	me, farm, st	reet, factory	, office			28f. Location (Si City or Town	treet and Numb n. State)	er or Rui	ral Route Number,
	pitel ours a serel C		29a. Certifier Certifying	Physician: To the bes	t of my know	wledge deat	h occurred	at the tim	e date an	d place	and due to the e	auca(a) and me		etatod
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Af completely filled in by the fur	edical	(Check only 2 Medical Ex	aminer: On the basis and mapner s	of examinat	tion and/or in	vestigation	, in my op	oinion, dea	th occurr	ed at the time, d	ate and place,	and due	to the cause(s)
	To ti withii To ti comp	Z	29b. Signature and title of certifier	7/1			290	. License	number		2	9d. Date signe	d (Month	. Day, Year)
			/ Zh	/ _				D	23979			12/5/	2005	
5	+VA	18	30. Name and 19019 s of person wh					C+	0-1-1	0 - 1	MJ 01	EEO		
	Sta	ite	Robert A. Gora	32. Regis	311 trar's Signa		urth	St.,	Uakl	and,	Md. 21.	220		
	Registi		DEC - 6	2005		As A	Asea.	nage .						

			1 - For Amend #19b,	12-1-0	Marylan pe r	HDR Ce	HCHD at	lealth and Death	Mental Hyg	piepe 05	40414	
	* 2 2 2 E	ž)	1. Decedent's Name (First, Middle, La						2. Date of Dea	th	3. Time of Death	
	Physici /Medi		Jeffrey Lee Ket	elslege	r				Novembe	er 27, 20	05 7:10 P M	
	Examir		4a. Facility Name (If not institution, given	e street and nur	nber)		4b. City, Town, or	Location of Dea	th	4c. County of D		
4.		Q	Casey House 5. Social Security Number 6.5	2au	7 Ann //n	to a de la facto sta	Rockville	If Under 24 Hr	S D D (B) #	Montgom		
K	Funeral Director		214-60-8426	Sex IXIM 2□F	7. Age (In yrs.)	2 Yrs.	Months Days	Hours Min	. (Month, Day	, Year)	Birthplace (State or Foreign Country) innesota	
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits	
	Many -1 eh	to	Maryland Montgome	2 * 7	Silv	er Spr	ina				1 ☐ Yes 2 🛣 No	
	r 28s	Director	10e. Street and Number	- <u>-</u> ,	BIIV	CI DPI	10f. Zip Code		1	0g. Citizen of What	t Country?	
	th wit	aiD	10431 Huntley Ave	enue			20902			USA		
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f show eny injury or other traumatic event, I'm Medical Examinar must be multiped at once.	Funerai	11. Marital Status 1 ☐ Never Married 2K Married	Armed Fo 1 ☐ Yes	2 📉 No		Was Decedent of H	in, Mexican, Pue			American Indian, Vhite, etc.	
9	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da			1 □ Yes 2XXVo	Specify:		Specify:	White	
5-0	72 h	etec	15. Decedent's E (Specify only highest gr			(Give	dent's Usual Occupa	during most of wa	orking	16b. Kind of Busine	ess/Industry	
21215-0036	within ane. than	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retired)		D1		
d 2	filed v Hygie ther	သို	17. Father's Name (First, Middle, Last)		Sales	sman	18. Mother's Na	me (First, Middle, I	Books Maiden Sumame)		
Maryland	ld be ental ked o	To Be	LeMar Ketelsleger						th Jean F			
ary	shou and M mar umat	۲	19a. Informant's Name/Relationship (Туре, Print)		19b. Mailir	ng Address (Street	and Number or F	lural Route Number	City or Town, Stat	re, Zip Code)	
	and 2		Margo Schwab/Wife	1					ver Sprin			
ore	of He of He filten		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐		1 0	lace of Dispo	sition (Name of natory or other plac			20c. Location - City		
Ĕ	Pag tment tant: jury c		4 □Donation 5 □ Other (Special		Che	-	te Cremato	-			e, Maryland	
Baltimore,	Depermit Deper Impor	21. Signature of Funeral Service Licenses (Coing Home Cremation Service P.O. Bo										
E	# /		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that co	aused the death	. Do not ent	er the mode of dying	g, such as cardia	ic or respiratory arm	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a Metas	tatic B	ladder	Cancer				Onset and Death	
1	/Medical Examiner		resulting in death)		or as a consequ		Odirect					
3	- Administr	-	Sequentially list conditions,	b. Phys. to F	or as a consuqu	connect (f):						
	rted	nine	Sequentially list conditions, I any, leading to any ediate cause. Enter Underlying Cause (Disease or injury	20017	ar de discriscoqu	or and only					1	
~	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):						
8760,	icate be executed physician and the burial-transit	dicai		_ d								
Θ	ng ph as th	Medi	IF FEMALE:									
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	ding Physician: h. After this certific funeral director.	۲.	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date o		ER/Outpatien 28b. Time of		4 Nursing i		ence 6 Other (S	Specify) hospice	
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ā	tal or s afte al Dir	Certification;	4 Homicide	buildir	ng, etc. (Specity)			City or Town	i, State)		
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	nysician: To the miner: On the ba and mann	isis of examinat	vledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner ate and place, and c	as stated. due to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	11	>		29c. License	number	29	9d. Date signed (Mo	onth, Day, Year)	
)			CLERT.	11	<u> </u>		DU	1121	N	ovember 2	29, 2005	
) a	0		30. Name and address of person who Charles Harrison					Rockvil	le, MD 20	855		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1 20	05 32 A	egistrar's Signat	ure do	entis					
	108	* V				Prince	- Cross					

Amend #23 A per PHY. 11-30-05 AA Co. Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Katherine E. Korn November 27, 2005 4:26 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs. 10-29-1912 577-10-1254 Director Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic event, the Mudical Exeminar rount by notified at 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 803 Coxswain Way, Apt. 209 21401 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene. markad other than "natural", or Ite 1 □Yes 2X No 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Salon 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic avant, gonca. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Korn Katherine C. Bladt 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Troutman/ Sister 803 Coxswain Way, Apt. 209, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD 11-29-05 Kalas Crematory 21. Signature of Fundral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Immediate Cause (Final disease or condition resulting in death) Agonal **Physician** /Medical Due to (or as a consequence of) Examiner Lethara Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Rend Padvie Division of Vital Records, P.O. Box 68760. Physician/Medical as the ettending IF FEMALE. use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetat death 3 Ectopic pregnancy 1 Live birth Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ZNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANaturat 5 Pending Injury 1 Tes 2 No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) D61829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KETWALDO LEE- LLACE R
31. Date filed (Month, Day, Year) 32. Degistrar's Sign 2108 D. Donato Drive, Charter MD 21619 32. Aegistrar's Signature State 2 9 2005 Registrar

1 - For State Registrar Certificate of Death

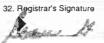
1			1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
	Physici		Abraham	K	ramer			Nov. 25	2005 Year	11:11a ^M
, e	/Medi Examir		4a. Facility Name (If not institution, gi Casey House			4b. City, Town, o	or Location of Death		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. 124-20-1483	Sex 7. Age (In	yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/22/	Year) 9. Birth Con 1925 Nev	nplace (State or Foreign intry) W York, NY
	pu ,		Usual Residence of Decedent	140	- Cir. Tanana					
	e Maryla te-f ehov	ctor	MD Montgo	omery	Silver					10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
	th with th	ai Dire	3431 South Let		Apt.2D Blvd	10f. Zip Code 2 (908	10	og. Citizen of What Cou USA	untry?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "neturel", or Iteme 23a or 28e-f show any injury or other traumatic event, It e Medical Examinations in notified.	t by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	d within 72 h giene. er then "netu	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) 2	(Give	dent's Usual Occup kind of work done DO NOT use retired [anager	during most of work	ing 1	Plumbine	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic event, the Missian Mental Count, the Miss	To Be (17. Father's Name (First, Middle, Las Phillip Kramen				18. Mother's Name Matil	da Gold	faiden Sumame)	
	alth and N		19a. Informant's Name/Relationship Mark Kramer/S		19b. Mailir 118	ng Address <i>(Street</i> 12 Quin	and Number or Run	Drive	North State, Zi Potomac, M	ip Code) Id 20878
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec.	Removal from State	Ob. Place of Dispo	sition (Name of natory or other place	(90	Date 2	oc. Location - City or T	own, State
Balt	permit. Departr Imports any init		21. Signatury 1 Funeral Service Co	75	22 E	HTLIP OF COLUMN	% RIWALD umbia B	I FUNER	AL SERVIO	CE, P.A. ng, Md2091
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		d Non-S		ell Lung			Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsaquence of).					
68760,	leath certificate be executed ettending physicien and I for use as the burial-transit	cian/Medical Examiner	that initiated events resulting in death) Last	c. Due to (or as a col	nsequence of):					
O. Box	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliv Month	ery Day Year
Δ,	p o	by	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ndertying cause giv	en in Part I.		acco use contribute to	the cause of death?
I Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform	ed? prior to co	opsy findings available ampletion of cause of
Vital	slcian: certific irector,	Be (25. Was case referred to medical examiner?				26. Place of Death	Check only one	1	
of V	O S	2	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Residen	nce 6 XOther (Speci	hospice
	ding After fune		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea n	28b. Time of Injury	Wor	y at k? Yes 2 ☐ No	28d. Describe how	v injury occurred	
Division	를 다 다	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - building, etc. (S)	At home, farm, stropecify)	eet, factory, office		281. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 Certifying P	hysician: To the best of my mirrer: On the basis of exa and manner stated.	knowledge, death mination and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1111		29c. Licens	e number	290	d. Date signed (Month,	Day, Year)

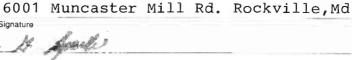
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State Registrar 31. Date filed (Month, Day, Year)

Charles Harrison MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





Saminer As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution, give street and number) As Facility Name (if not institution) As Facility Name (1 - For State Registrar		State of N	Marylan		partme	ent of H					e nn e) L	04	17
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The state of the control of the cont	Funeral		5. Social Security Number			Age (In yrs.	iast birthda					8. Date of Bir	th	-)	9. Birthp	lace (State	or Foreig
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Medical Examiner			snock, or near failure.	ist only o	ne cause on each	line.	i. Do not e	inter the m	ode or dylin	y, such as (cardiac c	r respiratory ai	rrest,			Interval Be	etween
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State 31. Date filed (Month, (Lev. Year) 2005	2,500																
			31. Date filed (Month, Day, Ye	30 2	32. Re gis	trar's Signat	ure	Lack	_0								

			1 - For State Registrar	State of M	larylan	nd / Depa <i>Cei</i>	artmen rtificat	t of H	ealth a Death	and M	ental H	giene Reg. No.	105	Total State	0418
AC.	Physici	an	1. Decedent's Name (First, Middle, Las	Sara Ar	ın KA	т <i>7</i>					2. Date of D	Day	Ye	ear	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death	Nov	32 7 4c. €	County of	Death	8.05 P W
***		*	Shady Grove Adver	ntist Hosp	oital			ckvi				M	ontgo	omer	У
	Funeral Director		5. Social Security Number 6. S 577-20-3057	ex 7. A	ge (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of B (Month, Dec. 5	irth lay, Year 192	0 Ma	Birthpla Country 1 T y I	ce (State or Foreign y) and
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	d. Inside City Limits
	88-1 e	ector	Maryland Montgome	ery	Ga	ithers									¹∏Yes 2□No
	with th	Dir	10e. Street and Number 106 Brookes Avent	1 e			10f. Zip		877			10g. Citize Un it			
	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28s-f ehow ta Medical Evarial at mas Lei calified at	Completed by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U		Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or N		4. Race -	Americar	n Indian,
30	s after	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No		1 🗆 Yes		Specify:	1, 1 0010 1	noan, etc./	5	Specify: T	White, etc	
3	2 hour	ted t	15. Decedent's Ed			16a. Dece	dent's Usua	al Occupa	ition				d of Busin		
7	ithin 7 18.	npie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	kind of wo DO NOT u	rk done d se retired	luring mosi)	t of workin	19				•
N	filed w Hygier ther th		17. Father's Name (First, Middle, Last)	۷		Own	er		18 Mothe	or's Namo	(First, Middle		ail S	store	9
au	lid be rked o	To Be	Jacob Wolfs								Levin	s, maideri S	umame)		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28s-1 show among vintry or other traumatic event. The Medical Evertires must be realised at an answer.		19a. Informant's Name/Relationship (7 Allen Katz, Son	Гуре, Print)		19b. Mailir 2024	ng Address 1 Dar	(Street a	nd Numbe	or or Rural Prive	Route Numi	ber, City or hersb	Town, Sta	te, Zip C MD	^{ode)} 20886
Battimore,	of Hei		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State		Place of Dispo	natory or o	ther place			ate		ation - City		
Ě	t. Pag rtment rtant: I	1	4 □ Donation 5 □ Other (Specify	·)	Arı	ington				1/29		Balt		e, MI	D
g	Departing Support		21. Signature of June al Service Licen	see	CILL	zuk A	SYCHT	ngry	s Hebr	ew F	uneral	Home	- D(2012
i i	1		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that cause	d the deat						, Wash		n, D(A	DO12 pproximate
	Physician		Immediate Cause (Final disease or condition	a Primary		itonea	1 Can	cer						C	nterval Between Onset and Death Months
	/Medical Examiner		resulting in death)	Due to (or as											
		er	Sequentially list conditions,	b. Due to (or as	a consaç	uanca ol).									
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. =											
8/00,	cate be executed physicien and the burial-transit	al Ex	resulting in death) Last	Due to (or as	a conseq	uence of):									
000	ficate physics the t	edicai		d											
DOX	leath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pr					23	d. Date of	delivery	
	The law requires that the death certifing the best been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant a 9☐ Unknown			Other (sp						Month	Dá	ay Year
7	res that igned b	by Ph	Part II. Other significant conditions co	ontributing to death t	out not res	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did	tobacco use	contribut	e to the	cause of death?
ğ	w require been sig should b										10	Yes 2∏	No 3] Probab	iy 4 □Unknown
Records,	e law o	Completed									24a. Was	psy	prior	to comp	y findings available letion of cause of
Vital		e Co	25. Was case referred to medical								1 Tes	ormed? 2 No	deat		No
>	ysician: iis certifica director,	ToB	examiner?	Hospital:	ent 2 🗌	ER/Outpatien	t 3 DO	A Othe			Check only e 5 ☐ Res	-14	Other (Specify)	
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time of Injury	2	8c. Injury Work	at ?		Bd. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
DIVISION OF	tten deat stor:	icati	2 Accident Investigation 3 Suicide 6 Could not be		iune - At he	omo form etc	M factor		es 2 🗆 N		Of Logation	Ctroot and	A /	Destrict C	
2	al or Attender after death	Certification:	4 Homicide determined	28e. Place of In building, e	c. (Specif)	y)	eet, factory	, onice		21	City or To	wn, State)	Number o	r Hurai H	loute Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best iner: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred restigation,	at the tim in my op	e, date and inion, deat	d place, ar h occurre	nd due to the d at the time,	cause(s) ar date and p	nd manne lace, and	r as state due to th	ed. e cause(s)
	To th within To th	Me	29b. Signature and title of certified					. License	number			29d. Date	signed (M	onth, Da	y, Year)
							1	ND				Nove	nber	28,	2005
	10		30. Name and address of person who o	Paul (Oraz Maza-			,								
	Sta	te.	Manish Agrawal, M. 31. Date filed (Month, Day, Year)	D., 9707 32. Registr		cal Cer	and the same of th		e, Ro	ckvi.	lle, M	D 208	350		-
	Registr		NOV 3 0 2	2005	181 1	H A	sali)	9							

			1 - For State Registrar	State of Ma		partment of learning		nd Mental Hygi	2005	40419
	Physici		1. Decedent's Name <i>(First, Middle, Las</i> Marie		nt			2. Date of Death Month Novembe	Day Yea	3. Time of Death 05 6:25 PM
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Wings		4c. County of De	
	Funeral Director		5. Social Security Number 6. Social Security Number 2 1 3 - 2 2 - 2 3 8 0 1 Usual Residence of Decedent	7. Age	(In yrs. last birthda 82 Yrs.	// If Under 1 Year Months Days		Min. 8. Date of Birth (Month, Day, Nov. 13	^(ear) 1923 Ma	Birthplace (State or Foreign Country) aryland
	Maryland o-f show liled at	tor	10a. State 10b. County Maryland Calv	ert	10c. City, Town or	ocation Wings				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28e	Funeral Director	10e. Street and Number 361 Emerson Ro	ad		10f. Zip Code 20	736	10	g. Citizen of What	Country?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Items 23a or 28e-f show any figury or other traumatic event. The Medical Exam as must be notified at ODGE.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, Wi Specify: B 1	
Maryland 21215-0036	id within 72 h giene. er than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most o	f working	Someone Home	e Else's
yland	nould be file I Mental Hy narked oth natic event	To Be (eid		F1o1	Name (First, Middle, Ma Cence	iden Sumame) Rawli	
re, Mar	1 and 2 st Health and tem 27 is n		19a. Informant's Name/Relationship (7 Frances Harrel 20a. Method of Disposition		er 407	Quarry	Place			,MD 20743
Baltimore,	nit. Pages lartment of l ortant: If ite injury or o		1 □Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License)	Mt. Hop	e UMC C	em. 11	1/19/05 S	under1a	nd, MD
Ä	permi Depa Impo any in	0 6	Hlady q.	Sewell	P	rince F	rederi	Sewell Fu ach Rd. ck, MD 20	678	ome
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. LUNG	CANC consequence of):		ng, such as ca	rdiac or respiratory arres	•	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):					
8760,	ficate be executed physician and is the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	consequence of):					
.O. Box 6	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	y		23d. Date of de Month	elivery Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions co			inderlying cause giv	en in Part I.			to the cause of death?
									prior to death?	autopsy findings available completion of cause of s
Zit	nyaician: Th nis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	ot 3CI DOA Oth	or	Death (Check only one)		-11
Division of Vital	ding PI I. After th funeral	Pro 16	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur	y at	ng Home 5 V esidence 28d. Describe how		ecify)
Divis	itel or Attencus after death	Certification:	3 Suicide 6 Could not be determined	building, etc.				28f. Location (Stree City or Town, S	tate)	
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or ir	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	lace, and due to the caus occurred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	Men	f no	29c. License	e number 0233		Date signed (Mon	
	4		30. Name and address of person who co				W. T. 21	o prince Fl		
	Stat Registra	.6	31. Date filed (Month, Day, Year)	32. Registry	Signature	A.W.	VII 31	o promote pri	TOURS /7	20678

		1	For State Registrar	State of Maryland		rtment of H		ntal Hygier		40420
			Decedent's Name (First, Middle, Last)				2	. Date of Death		3. Time of Death
	Physicia /Medic	an al -	CHESTER Potso	, a Laws	04			120	Yeer Yeer	1250 AM
	Examin	er	4a. Fecility Name (If not institution, give si	lesse Road		4b. City, Town, or	dsoille		4c. County of Death	11
	Funeral Director		5. Social Security Number 6. Sex	M 2□ F 7. Age (In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Pay Yes 9/29/190:	9. Birth Cou	place (State or Foreign ntry)
			Usual Residence of Decedent							
	Marylan f show	to	10a. State 10b. County Preston		eton M					10d. Inside City Limits 1 ☐ Yes 2 No
	th the	lirec	10e. Street and Number			10f. Zip Code			Citizen of What Cou	intry?
	ath wi	ia	Rt. 3 Box 235			26525			U.S.	and lading
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinations to notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	11	/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Specif in, Mexican, Puerto Ric Specify:	ry Yes or No- can, etc.)	14. Race - Ameri Black, White Specify: Wh:	
15-0	in 72 ho n "natur fedical	Completed	15. Decedent's Educ (Specify only highest grade		(Give k	ent's Usual Occup- ind of work done of O NDT use retired	during most of working		Kind of Business/Ir	ndustry
212	e filed within al Hygiene. I other than " vent, the Mu	E	Elementary/Secondary (0-12) 8th	College (1-401 3+)		Farmer			Agricult	ure
and	t be filed ntal Hygied ed other	Be	17. Father's Name (First, Middle, Last) Robert Lawson				18. Mother's Name (A			
Maryland 21215-0036	d 2 should be h and Mental 7 is marked traumatic ev	은	19a. Informant's Name/Relationship (Type Sandi Wakefield	e, Print)			and Number or Rural F			
ď.	ages 1 and 2 out of Health t: if item 27 i y or other tra		20a. Method of Disposition 1XX Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	moval from State		ition (Name of atory or other place emetery	Dat 12/8/2		Location - City or Tuceton Mi	
3altin	permit. Pages 1 Department of H Important: If ite any Injury or ot 20008.		21. Signitule of Funeral Service License		22.	Name and Addres	ss of Facility Carl	R. Spear	Funeral	Home
	40240		23a. Pert1. Enter the disease, or compile shock, or heart failure. List only on	cations that caused the death	n. Do not ente	randonvi r the mode of dyin	11e Hgts,	Rt. 5 Borrest,	26525	Approximate
	Priysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	luas					Interval Between Onset and Death 4 North S
o,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
8760,	ate be hysicia the bur	dical								
.O. Box 68	aath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of degical Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Date of deliving Month	very Day Year
<u>α</u>	uires that the de signed by the id be detached	b	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	e law has b	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vital		BeC	25. Was case referred to medical examiner?	0.1571			26. Place of Death	Check only one)	-78	
of V	d S	10	1 ☐ Yes 2 No	ospital: 1 Inpatient 2			4 Nursing Home	d. Describe how in	6 Other (Spec	ify)
	ding After fune	ion	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □No	d. Describe now ii	njury occurred	
Division	the the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre			If. Location (Street City or Town, St	t and Number or Rui fate)	ral Route Number,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical Ce	29a. Certifier Check only one) Certifying Physical Exemition (Check only one)	sician: To the best of my knoter: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tirestigation, in my o	me, date and place, an opinion, death occurred	id due to the cause I at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier	.00. 2	ല	29c. Licens		29d.	Date signed (Month	_
	10		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, I	Print)	es Du c	no Var		```
		ate	31. Date filed (Month, Day, Year) DEC - 6	32. Registrar's Signa	ature	A M	C) AA	JU FAIL	1 2100	
	Regist	Tal	טבט ט	- Contract of the second	D.					

			1 - For State Registrar	State of	Marylar	nd / Depa	artmen rtificate				lental H	ygien	00	5 4	NL21
		175	1. Decedent's Name (First, Middle, L.	a <i>st)</i>							2. Date of D	eath		0 1	3. Time of Death
	Physic /Medi		William Franklin	n Lewis							Novem!	oer 2	27 ,	2005	3:33 P M
	Exami		4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location of	of Death		40	c. Count	y of Death	
			Montgomery Genera	ıl Hospit	al		01ne	У				Mc	ontg	omery	
	Funeral Director		577-50-5256	Sex 7	. Age (In yrs.	last birthday) 69 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, 1) Feb 3	irth Day, Year 193	36	9. Birthpl Coun Mary	lace (State or Foreign try) Land
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1/	Od. Inside City Limits
	Marylan f show	ō	Maryland Mantage	***											1 ☐ Yes 2 No
	28a-	rect	Maryland Montgome	: L y	Gal	thersb	10f. Zip	Code				10a Ci	itizen of	What Coun	
	3a or	۵	8000 Warfield Roa	ıd			208					USA		vviiat oodii	
	death ms 2	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in L	J.S. 13. \			spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)		14. Ra	ce - America	an Indian.
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta M. dical Examinat by ricilling at	F	1 Never Married 2 Married	Armed Ford	es? □XNo					i, Puerto	Rican, etc.)			ick, White, e	
03	rail, o	l by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dat	es:		1 🗆 Yes 2	2LANo	Specify:				Speci	^{∱:} Whit	:e
5-0	72 h	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usua	l Occupa	ition	t of work	na	16b. K	(ind of E	Business/Ind	lustry
21	ithin ne.	idu	Elementary/Secondary (0-12)	College (1-4	lor 5+)		kind of wor DO NOT us)		9				
2	be filed within 72 hatal Hygiene. d other than "natu		17 Fabrus Name (First Middle Land	5+		Stati	stici								ch Service
anc.		Be	17. Father's Name (First, Middle, Las John Alexander Le					1			(First, Middl		n Suma	me)	
Ž	should be filed withind Mental Hygiene. I marked other than umatic event, Ite M	2									loy LaF				
Maryland 21215-0036	2 60 60		19a. Informant's Name/Relationship	, , , ,							d Route Num				Code)
	s 1 and 2 of Health item 27 i		Kasey Milano/daug	hter	20b. I	8000 Place of Dispo	Warti	eld :	Road		hersbu				un Stato
5	ages nt of t: if it		1 Burial 2 Tremation 3			Place of Dispo				200	mber 3				
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or othe	1	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		CITE	sapeak									Maryland
Ba	Depriment of the point of the p		130011	1/2/14	+						n Serv				
2,	4		23a. Part1. Enter the disease, or con	nplications that cau	ised the deal	th. Do not ente	ever1	y L.	Heck	rott cardiac c	e, P.A	. CI	ark	sville	Approximate
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on eac	ch line.			, ,	,						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Metast	atic C		ancer								
	Examiner		1	00) 03 600	as a consec	querice or):									
V		Je.	Sequentially list conditions, if any, leading to in reclate cause. Enter Underlying Cause (Disease or injury	b. Una to (or	as a conseq	quance of):			-						
	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events	C											
ó	an ar rial-ti		resulting in death) Last		as a conseq	(uence of):									
8760,	ysicii	dicai		_ d.											
9	certifica nding ph	Jed	In Fermine												
Вох	death certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pre	onanov.					23d. Da	te of deliver	у
	death e atter ed for u	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (spe						Mo	onth [Day Year
P.O.	that the died by the detached	hy	9 🗆 Unknown												
Ś	se da	by 6	Part II. Dther significant conditions	contributing to dea	th but not res	ulting in the ur	derlying ca	use give	n in Part I.		23e. Did	tobacco i	use con	tribute to the	a cause of death?
ord	w requires been sign should be										1 🗆	Yes 2	X) No	3 🗌 Proba	bly 4 DUnknown
Vital Record	aw Is b	Completed									24a. Was		24b.	Were autop	sy findings available
œ	0 5 0	EO									auto perf 1 🗆 Yes	ormed? 2 ANo		death?	pletion of cause of
ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only			103 2	20 140
>	W 17	To E	1 ☐ Yes 2 ☐XNo	Hospital: 1 XInp	atient 2	ER/Outpatient	3 DO	Other			ne 5 □ Res		6 🗆 Oth	er (Specify)	1
	iding Phy th. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of	Injury Day Year)	28b. Time of Injury	28	lc. Injury Work			8d. Describe				
Ö	Attending r death. ector: After oy the fune	atle	2 ☐ Accident investigation	n	,,	,,	М		es 2 🗆 N	10					
	or Attendate death Director:	ertification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At he , etc. (Specif	ome, farm, stre	et, factory,	office		2	8f. Location (Street an	d Numb	er or Rural	Route Number,
	spital or Atten nours after deat neral Director: / filled in by the	O									O., O. 10	wii, Claib	')		
	Hospital 24 hours a Funeral I stely filled	edical	29a. Certifier 1 Certifying Pi	nysician: To the be	st of my kno	wledge, death	occurred a	t the time	, date and	place, a	nd due to the	cause(s)	and ma	anner as sta	ted.
		ledi	0.107	and manner	stated.					ii occuire	d at the time,	date and	place,	and due to t	ne cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier					License						d (Month, D	
•			· Whitelypus	ne-				12452	2			Nove	mber	28,	2005
2	62		30. Name and address of person who					D	#227	0.1	100	200	20		
1	V°		Chitra Rajagopal			nce Phi	гтттр	υr.	#32/	Oln	ey, MD	208	32		
196	Sta		31. Date filed (Month, Day, Year)		strar's Signa	iidle									

			For State Registrar	State of I	Maryland / De C	partment of F ertificate of	lealth and Death		giene 05 (+0422
			Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ith Day Year	3. Time of Death
	Physicia /Medic		Virginia Mae Lo	ıthan				Novembe	r 28, 2005	3:20 A M
	Examin		4a. Facility Name (If not institution,			4b. City, Town, o		ath	4c. County of Death	
		gradients.	Shady Grove Adv			Rockvi		rs. 8. Date of Birth	Montgomery	
	Funeral Director		5. Social Security Number 218–24–3483	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birthd 80 Yrs	Months Dave	Hours Mi	n. (Month, Day	Year) Virg	place (State or Foreign intry) zinia
			Usual Residence of Decedent							
	how		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits 1 Yes 2 No
	8a-f	cto	Maryland Montgo	nery	Gaithers				to- Chinas of Minas Co.	
	vith th	Dire	10e. Street and Number	#111		10f. Zip Code 20877			10g. Citizen of What Cou	
	e 23	era	101 Odend HalAv	12. Was Decede		3. Was Decedent of	Hispanic Origin?	(Specify Yes or No-	United Stat	
36	be filed within 72 hours after death with the Maryland tial Hygiene. dd other then "naturel", or Iteme 23a or 28a-f ehow event, I're Medical Examination in the notified at	by Funeral Directo	1 Never Married 2 Married 3 ⊠Widowed 4 Divorced	Armed Force	XNo	If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Pu Specify:	erto Rican, etc.)	Specify:	ite
8	2 hou		15. Decedent	s Education		cedent's Usual Occup			16b. Kind of Business/li	
21215-0036	within 72 ene. then "na	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4)	lit	ive kind of work done e. DO NOT use retire	during most or v d)	working		
21	giene grith	Com	12			nemaker			Own Home	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, L	.ast)				lame (First, Middle,		
yla	2 should be and Mental le marked of raumatic eve	ုင	George Hayton	· C · · · Direct	105.14	siling Address /Street		Anne Myers	r, City or Town, State, Zi	in Code)
Mar	D = 2 =		19a. Informant's Name/Relationsh Woodrow Wilson						thersburg,	
Baltimore, Maryland	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If Item 27 le marked eny Injury or other traumatic eny Injury or other traumatic eny lance.		20a. Method of Disposition 1 ★Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of Di cemetery. Forest Cemete	sposition (Name of crematory or other pla		cember 1,	20c. Location - City or T	
Baltir	permit. P Departme Importen eny Injur		21. Signature of Funeral Service L		Ochice	22. Name and Addre	ess of Facility	eVol Fune	eral Home, Gaithersburg	
ŵ.			23a. Fart V. Enter the disease, or	complications that cau	sed the death. Do not					Approximate Interval Between
-	Physician /Medical		shook brhean failure. List of the disease or condition resulting in death)	a	SEP					Onset and Death
96	Examiner			Due to (or	as a consequence of): JRIWAR	Y TRA	ICT 1	WFEC	TION	1 day
50,	cate be executed physicien and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of): OMGES as a consequence of):	TIVE	HEA	AT F	TION	1 day
68760,	physicate t	edical		d						
.O. Box (thet the death certificate be executed ted by the attending physicien and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mosths? 1 □ Yes 2 ᢓ No 9 □ Unknown		n 2 □ Fetal death t at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of delik Month	very Day Year
<u>α</u>	thet ed b deta	by	Part II. Other significant condition	ns contributing to deat	h but not resulting in th	e underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute lo	the cause of death?
of Vital Records,	e la has	Completed							24b. Were aut prior to commed?	opsy findings available ompletion of cause of
ital	sician: Th certificate rector, pag	0	25. Was case referred to medical		2		26. Place of D	Death (Check only o		
f V	8 S P	To B	examiner? 1 Yes 2 No	Hospital: 1 inp	atient 2 ER/Outpa			g Home 5 ☐ Resid	lence 6 Other (Spec	ify)
			27. Manner of Death 1. ■ Natural 5 ■ Pending	28a. Date of (Month,	njury 28b. Tim Day Year) lnju	ry Wo		28d. Describe h	now injury occurred	
Division	ten for: the	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	Injury - At home, farm, etc. (Specify)]Yes 2□No	28f. Location (S City or Tow	Street and Number or Rui m, State)	ral Route Number.
Ö	rs after or rel Dir	Cer								
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier Certifyin (Check only one)	g Physician: To the be Examiner: On the bas and manne	s of examination and/o	eath occurred at the to investigation, in my	me, date and pla opinion, death o	ccurred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Month	
	ri		P	and"	news		057	4	11/281	0 1
	1		30. Name and address of person Truong Bao, M.D	who completed cause . , 13219 Ex	of death (Item 23a) (Ty kecutive Pa	pe, Print) ark Terrac	e, Germa	intown, MD	20874	
•	Sta Regist		31. Date filed (Month, Day, Year)	2005 22. Reg	istrar's Signature	arke				

AKG	7201		For	State of Maryland / [Department of Health and	Mental Hygie	ene
			1 State Registrar		Certificate of Death		WOUND 40453
	Physici /Medi		1. Decedent's Name (First, Middle, Antonio	Jimenez	Lazaro	2. Date of Death Month October	Day Year 24, 2005 3:05 P M
	Examir	ner	4a. Facility Name (If not institution, g	'	4b. City, Town, or Location of Dea	th	4c. County of Death
	55	4	1100 block Linde		Takoma Park		Montgomery
	Funeral Director		5. Social Security Number 6 NONE	Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min		(ear) 9. Birthplace (State or Foreign Country)
	-46		Usual Residence of Decedent	20		12/19/	1984 Mexico
	yland		10a. State 10b. County	10c. City, Town			10d. Inside City Limits
	ith the Marylar or 28e-f ehow	ctor	MD Prince	e George's Rive	erdale		1 ☐ Yes 2 XNo
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Inportent: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow eny injury or other treumetic event, the Madical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 5609 54th Ave	enue	10f. Zip Code 20737	10g	Citizen of What Country? Mexico
	eep .	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
9	or it	YFL	1 Never Married 2 Married	1 ☐ Yes 2 1 No If Yes, Give	1⊠Yes 2□ No Specify: Me		
Ö	hour fural	d be	3 Widowed 4 Divorced	Year or Dates:			WILCE
15	in 72 "na" n	jete	15. Decedent's (Specify only highest	grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16	b. Kind of Business/Industry
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Concrete Worker	i	Construction
Þ	Hyg other	BeC	17. Father's Name (First, Middle, La	•		me (First, Middle, Mai	
<u>"</u>	Aenta Aenta rked tic ev	To B	Diego Jimenez	: Carino	Jacob	a Lazaro	Rodriguez
Maryland 21215-0036	d 2 shot th and h i7 is ma		19a. Informant's Name/Relationship Maria Jimenez	(Type, Print) 19b. Z Lazaro/Sister	Mailing Address (Street and Number or R 5609 54th Avenu	ural Route Number, C	ity or Town, State, Zip Code)
	1 an Heal tem 2		20a. Method of Disposition	20h Place of	Disposition (Name of	Data	c. Location - City or Town, State
Baltimore,	ages ant of tr. # 1		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special)	Removal from State Guade	ry crematory or other place)	'05/05 P	uebla, Mexico
重	artme orter injur		21. Signature of Funeral Service Lig	,,			
ä	Depar Impor	. 1	X4.Q. Oxunt	21	PHILIP D. RINALD	OL FUNERA	L SERVICE,P.A. er Spring,Md20910
	Physician /Medical Examiner	ər	snock, or neart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. BUNT FORCE Due to (or as a consequence of b.	of):		, Approximate Interval Between Onset and Death
	te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c			
760,	ite be exe iysician a ne burial-		resulting in death) Last	Due to (or as a consequence of	of):		
87		dical		d			
Division of Vital Records, P.O. Box 68	or Attending Physicien: The law requires thet the death certifica the death. Jirector: Atter this certificate has been signed by the attending pr in by the funeral director, page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
σ.	thet the d ed by the detached	P	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I	23e Did tobac	co use contribute to the cause of death?
ds,	uires the signed Id be det			,	and distance giron in Fact.	1 ☐ Yes	2 No 3 Probably 4 □Unknown
5	w requir been si should	ete				045 1455	
al Re	The lav cate has	Completed				24a. Was an autopsy performed	
Şi.	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	0.4	ath (Check only one)	
5	Phys this ral dir	.T	1 X Yes 2 No 27. Manner of Death	1 Inpatient 2 EH/Out			e 6 Rother (Specify) at scene
L C	ding f h. After funer	tion	1 ☐Natural 5 ☐ Pending	(Month, Day Year) In	ime of jury at Work? 2 3 200 M 1 Yes 2 1 No	28d. Describe how i	4 00 11 000 1
isi	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not	be Oss Plans of Island At home for		SVBTEC	
<u>~</u>	after Dire	ertii	4 Momicide determine	building, etc. (Specify)		City or Town, S	it and Number or Rural Route Number, itate) AVE, TAKO ITA PARK, ITD
	To the Hospitel or within 24 hours af To the Funerel D completely filled it	edical C	29a. Certifier 1 Cartifying F (Check only one) 2 Medical Ex-	Physician: To the best of my knowledge, aminer: On the basis of examination and	, death occurred at the time, date and place	and due to the cause	a/s/ and manner as stated
	thin the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	To To Con		Cau A		OCME		ctober 25, 2005
	0		20 Name and address of access in	o completed cause of deeth (them 22 1 5	Type Print 111 De Ct		
-			ANA RUBIC	070,0	Type, Print) 111 Penn Stree	er Baltimo	ore, Maryland 21201
	Sta Registr		31. Date filed (Month Pay, Year)	2005 32. Fegistrar's Signature	Sporte		

			1 - State Amend Item #5	State of Ma per FH G85	1710706 1710706	rtment of H	lealth and Death	Mental Hyg	iene	1.01.21.
	Physici		Decedent's Name (First, Middle, Last CHARLES	JOSEPH	MATHIEU	ī		2. Date of Dear Month November	th Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give Carroll County	street and number)		4b. City, Town, or Westmi			4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Se 216-24-7294 10		(In yrs. last birthday).	If Under 1 Year Months Days		8. Date of Birth (Month, Day, FEB. 5,	Year) 9. B	irthplace (State or Foreign Country) Lryland
	Maryland I-f show	tor	Usual Residence of Decedent 10a, State 10b. County Maryland Montg	gomery	10c. City, Town or Loc Mount	Pation Airy				10d. Inside City Limits 1 ☐ Yes 2 🚻 No
	h with the 23a or 28e	al Director	10e. Street and Number 9250 Brown Churc	h Road		10f. Zip Code 2177	1	1	Og. Citizen of What C	Country? States
036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jisal Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	o If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:	
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5-	(Give I	ent's Usual Occupa kind of work done of O NOT use retired	during most of wo f)	rking	16b. Kind of Busines Utility (,
yiana,	2 should be filed and Mental Hygin Is marked other raumatic event, It	To Be C	17. Father's Name (First, Middle, Last) Charles	Ε.	Mathieu		Helen		mple	
	s 1 and 2 should f Health and Mer ftem 27 Is marke other traumatic	S S	19a. Informant's Name/Relationship (T) Judith Mathieu	ирө, Print) / Wife					City or Town, State, Airy, MD	Zip Code) 21771
Baitimore,	Pages 1 lent of He nt: If iten ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Dispos cemetery, crem Montgomery	atory or other plac			20c. Location - City o	
מפוב	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		21. Sign tury of Funeral Service Licens		22.	Name and Addres	ss of Facility St	auffer F	uneral Hom nt Airy, M	nes, P.A.
	Physician		23a Part . Enter the disease or completion of the control of the c		the death. Do not ente Myocardial			c or respiratory arre	est,	Approximate Interval Batween Onset and Death
	/Medical Examiner	er	resulting in death) Sequentially list conditions, if any, leading to immediate	Diabet	consequence of): Ces Melliut consequence of):	us				years
8/60,	The law requires that the death cartificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Examiner	Cause. Enter Underrying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a	l obesit consequence of):					years
0	ntificate ng phys s as the	Medical	IF FEMALE:	ı. ııyıert		years				
.O. DOX	that the death cartific ed by the attending p detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 9 ☐ Unknown	! ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
Hecords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con		not resulting in the unitary Artery					to the cause of death?
		Completed	Peripheral Vascu Benign Prostrate			ssion		24a. Was ar autopsy perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of s 2 2 No
IOII OI VITAI	Attending Physician: Thr r death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Satural 5 Pending 2 Accident investigation	lospital: 1 Inpatien 28a. Date of Injury (Month, Day	t 2 X ER/Outpatient 28b. Time of Injury	3 DOA Othe	ome 5 Residence	nce 6 Other (Spe	acify)	
DIVISION	the state of the s	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc.				City or Town,		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of ner: On the basis of a and manner state	my knowledge, death examination and/or inve ed.	occurred at the timestigation, in my op	e, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
•	To t To t	Σ	29b. Signature and title of certifier	Rill	In MO	29c. License D54749	number		od. Date signed (Mon November 2	
	10		30. Name and address of person who co		ath (Item 23a) (Type, P	rint)	D-1, Fre			21701
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1 20	22 Majatan			-			

				State of W	arylari		ertificate of		, ,	2.00	5	40425
			1. Decedent's Name (First, Mide	die, Last)					2. Date of Death		Year	3. Time of Death
	Physici /Medio		Paul A. Maust						December			4:37 PM
	Examir		4a. Facility Name (If not instituti	on, give street and number))			4b. City, Town, or L	ocation of Death	4c. County	of Death	n
			Goodwill Menno				(au) If Under 1 Year	Grants				rett
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. la	a <i>st birthd</i> Yrs	Months Days		(Month, Day,			nplace (State or Foreign untry)
	Director		212-24-2264 Usual Residence of Decedent	**	82				April 3,	1923	Ma	ryland
	yland IOW		10a. State 10b. Count	у	10c. City	, Town o	r Location					10d. Inside City Limits
	a-fst	ş	Maryland Garre	tt	Gr	ants	ville					1 ☐ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number			-	10f. Zip Code		10	g. Citizen of \	What Cou	untry?
	ath w	la l	520 Crab Run Ro	ad				536		USA		
	er deg	une	11. Marital Status	12. Was Decedent Armed Forces?		3. 1	 Was Decedent of If Yes, specify Cul 	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Pican, etc.)		e - Amer ck, White	rican Indian, e, etc.
2	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 🛱 Widowed 4 ☐ Divorce	M Voc Chio	No		1□ Yes 2 No	Specify:		Specify		4-1
3	should be filed within 72 hours after death with the Maryland ind Mental bylgiene. Indextad other then "natural", or items 23e or 28e-f show umatic event, the Medical Evaluation must be indiffied at	ed	15. Decede	nt's Education		16a. De	ecedent's Usual Occu	pation	1	6b. Kind of B		hite ndustry
2	hin 72	Be Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)	5+1	(G life	ecedent's Usual Occu live kind of work done le. DO NOT use retire	during most of worked)	king			,
7	d with	E	8	College (1-40)		Farm	ing/Salesm	nan	A	gricul	ture	/Sales
2	at Hy d other	Be (17. Father's Name (First, Middle	, Last)				18. Mother's Nam	e (First, Middle, M	laiden Surnan	10)	
7	Ment Ment arkac	_	Allen J. Maust					Alma J.				
<u> </u>	l 2 sh n and ls m raum		19a. Informant's Name/Relation	ship (Type, Print)			ailing Address (Stree					
5	1 and Health sm 27 ther 1		Esther Beitzel, 20a, Method of Disposition	Daughter			Mason-Dix sposition (Name of crematory or other pla		-	Sdale, Oc. Location -		15552
2	ages int of t: If its		1X Burial 2 ☐ Cremation					י ביי	c.10,05			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mantal Hygiens. Primportant; if fam 27 is marked other then "natural", or frems 23e or 28a-f show any Injury or other traumatic event, the Medical Evaniner must be putified at once.		4 □ Donation 5 □ Other (a	• • • • • • • • • • • • • • • • • • • •	PILL.		r Mennonit			itting	er,	Maryland
ב ב	Depar Depar Impor any ir		D Draw	De mari			22. Name and Addr Newman Fur			MD 03	-26	
			23a. Part1. Enter tile disease, c shock, or hit failure. Lis	or complications that caused	the death.		P.O. Box 2 enter the mode of dy				536	Approximate Interval Between
	Physician	0 7	shock, or heart failure. Lis	t only one cause on each li	ne.						į	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition	a Advan	coal	A	mystroph	ic Lation	al Sc	leros	1.5	1/241.
	Examiner	_	resulting in death)	a. 1 (0 · V ·			sequence of):	, _				
	be sign	ulue		- LONG	n ES	FIV	E) Hec	irt ta	TLURI	5		IYR
	xecut and al-trar	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	41-		1 -	sequence of):	Nuc Oil	A C 1 A		İ	4. 0
3	siciar siciar e buri		that initiated events	a NEU		00	sequence of):	DAZIM	TUIT			14K
3	ifficat g phy as the	Medical	resulting in death) Last	()	May		Avtery	Air.	98	,	-	7400
5	endin r use			d. C010	rucr		1111000	18750				2115
:	e deat	Physician/	Part II. Other algnificant conditi	ons contributing to death b	ut not resul	ting in the	e underlying cause gi	iven in Part I.	23b. Did tob	acco use cor	tribute t	to the cause of death?
•	d by t		Hunga tions	sion, As	nivo	die	n		1 □ Ye	s 2 No	3 ☐ Pro	obably 4 Unknown
5	res the signed the control of the co	l by	The Care	5101)	7	011					0.45 14	fore autonou fin dings
5	need	Completed							24a. Was an perform		av	Vere autopsy findings vailable prior to completion of cause
2	elaw has ge 2	d L										death?
5	n: Th ficate or, pa	ပိ	25. Was case referred to medical					OC Place of Past	1 ☐ Yes		1	☐ Yes 2屆No
•	s cert	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2∏ F	R/Outpat	tient 3 DOA Ot	hor:	h <i>(Check only one</i> me 5□ Residen		ar (Sneci	WAssisted
5	g Phy er this		27. Manner of Death	28a. Date of Inju		28b. Time Injun	of 28c. Inju		28d. Describe hov			Living.
5	ath. or: Aft	atlo	E LI 7 GOIGOIII	igation	, , , ,	irijai;		Yes 2□No				J
É	irecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr		ury - At hon c. <i>(Specify)</i>	ne, farm,	street, factory, office		28f. Location (Stree City or Town,		er or Run	al Route Number,
)	oltal o		00-0-48									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		ng Physician: To the best on Examiner: On the basis of and manner sta	examination							
	vithin of the	Me	29b. Signature and title of certific				29c. Licens			d. Date signed	(Month,	Day, Year)
	, , , , ,		Salsahat	- Normal	/		D5	8655		12/6/	05	•
	1		30. Name and address of person	who completed cause of	eath (Item 2	23a) (Typ	pe, Print)	C. A = =		1. ^	2	-2/
	T		SABAHAT N	MWAB, 32	COVP		te DR;	UKANTS	VILLE,	MD.	415	556.
	Stat Registra		31. Date filed (Month, Day, Year, DEC -	6 2005 32. Registra	ar's Sign / atu	ire M	Anad .					
	negistr	ell.	DEC	1000	400 1	15	Mary Sand Shad					

			For State Registrar	State of Man		artment of H			iene () ()	5 40426
	Physicia	20	1. Decedent's Name (First, Middle,	Last)				Date of Deat Month	Day	3. Time of Death
	/Medic			Margraff				December		
	Examin		4a. Facility Name (If not institution,			4b. City, Town, or		ath	4c. County	
			Goodwill Mennoni 5. Social Security Number 6		n yrs. last birthday)	Grants	V1 J. LE If Under 24 H	rs. 8. Date of Birth		9. Birthplace (State or Foreign
	Funeral Director		220–10–1172	1[XM 2□F 9]		Months Days	Hours Mi	n. (Month, Day, Nov. 5,	Year)	Country) Maryland
			Usual Residence of Decedent							
	arylar show	_	10a. State 10b. County		0c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 No
	8e-f	ecto	Maryland Garret	t	Accide				0g. Citizen of W	
	with the	Funeral Directo	10e. Street and Number	- 4-		10f. Zip Code 215	20		USA	vnat Country?
	ns 23	era	103 S. Main Stre	12 Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi	spanic Origin?	(Specify Yes or No-		e - American Indian,
0	r Iten	F	1 ☐ Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 X No		If Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		k, White, etc.
<u>8</u>	72 hours after death with the Maryland natural; or Items 23a or 28e-1 show deal Extra from the notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 AYes 2□ No	Specify:		Specify	White
21215-0036	be filed within 72 hours after death with the Marylar Ital Hyglene. Id other then "natural; or frems 23a or 28e-1 show event, the Medical Exterities must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	vorking	16b. Kind of Bu	usiness/Industry
121	within ne. hen '	mp	Elementary/Secondary (0-12)	College (1-4or 5+))		m:	la aug
22	filed within Hygiene. Ither then "		17. Father's Name (First, Middle, Li	est)	Seli-	employed	18. Mother's N	lame (First, Middle, M		ber
au	Mental Mental arked o	To Be	George Margraff				Mary F	ratz		
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiens. item 27 is marked other then other treumatic event, the M	-	19a. Informant's Name/Relationshi	o (Type, Print)	19b. Maili	ng Address (Street a		Rural Route Number	, City or Town,	State, Zip Code)
ž	P = N =	3	Karen A. Knight/	Daughter	140 F	riendsvil	le Road	, Markley	sburg,	PA 15459
altimore,	permit. Pages 1 an Depertment of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	_	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	Θ)	Date	20c. Location -	City or Town, State
Ĕ	Page ment ent: I		`4 □Donation 5 □Other (Spe		St. Paul'	s Cemeter	y Dec	.8,2005 A	ccident	, Maryland
3alt	permit. Deperti		21. Signature of Funeral Service Li	censee				mes, P.A.		
<u>~</u>	<u>a</u> 0==a		2 yeur	emore				, Grantsv		
П			23a, Part1. Enter the disease, or c shock, or hear failure. List of	Implications that caused the iny one cause on each line.	e death. Do not en		0	V	est,	Approximate Interval Between Onset and Death
a	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_a_ Conges	tive (sys	itolic) he	eart +	arlure		3yrs
	/Medical Examiner		Tooding in downy	Due to (o (as a o	consequence of):	a Harm	acla	nies		11116
		Ē	Sequentially list conditions, if any, leading to immediate	b. Div to (or as a c	consequence of):	Mouro	July	our		guas
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		5					
Ć,	sician and burial-transit		resulting in death) Last	Due to (or as a c	consequence of):					
760,	ate be ex physician the burial	icai	,	d						
9		Med	IF FEMALE:	1.00		· · · · · · · · · · · · · · · · · · ·			1	
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	⊒Ectopic pregnancy			23d. Date Mor	re of delivery nth Day Year
о. П	ie des the al	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□ Unknown	ne of death 5	Other (specify)				,
<u>α</u>	res that the de signed by the a be detached f	Ph	Part II. Dther significant condition	s contributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did tot	pacco use contr	ribute to the cause of death?
Records,	signe d be	d by	demonstin penis	heral Vascul	an disco	ue ch	ronic	1 □ Y€	s 2 No	3 Probabiy 4 Unknown
20	w requir been si should	ete	hand lailus	heral Vascus				24a. Was a	n 24b. V	Were autopsy findings available
Rec	ne lav e has ge 2	Completed	renal fully	e, 412				- autops perforr	y ned?	prior to completion of cause of death?
Vital	i clen: The lav certificate has rector, page 2	6)	25. Was case referred to medical				26 Place of F	1 ☐ Yes 2 Death (Check only on		Yes 2 No
	ysicle is carl direct	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	nt 3 DOA Othe		Home 5 Reside		er (Specify)
ō	ding Physicien: The n. After this certificate hit funeral director, page	T :u	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of	of 28c. Injun	at	28d. Describe ho		
Ö	ttending F death. :tor: After r the funer	atio	1 Natural 5 Pending 2 Accident investiga	ition	,,		Yes 2 □ No			
Division of	ter de irecto	Certification;	3 Suicide 6 Could no 4 Homicide determin			reet, factory, office		28f. Location (St City or Town	reet and Numb n, State)	er or Rural Route Number,
Ω	urs af		on Carlina Aria and	Dharida Tali	- Inc. In the second		an date of the	and the state of		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certifics completely filled in by the funeral director.	Medical		Physician: To the best of examiner: On the basis of examiner and manner state	kamination and/or in					
	o the ithin (o the omple	Mec	29b. Signature and title of certifier	. /		29c. License	e number	2	9d. Date signed	d (Month, Day, Year)
}	F 3 F 3		Marian of	attain M		D 760	1050		12-5	5-200x
	2		30. Name and address of person w	to completed cause of dea	th (Item 23a) (Type					
)		maracoret a	Kaiser und	13079	garrett h	iffwa	4 oak	land.	md 2/550
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1	U	/		
	Regist	rar	DEC - (2005	w St. A	100 ch				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:22AM M Paul Patrick Murphy 2005 Dec /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Barton 18701 Temperance Row If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 29, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 XM 2 ☐ F 81 Maryland 1924 Director 219-14-6485 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other treumstic event, the Medical Examiner must be nutilised at Allegany Barton 1 ☐ Yes 2 No MD. Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 United States 21521 18701 Temperance Row, Box 122 Items 23a filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. Tyes 2 No WW 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 5 white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 XDivorced Year or Dates: "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Paper Manufacturer Il Hygiene. College (1-4or 5+) Etementary/Secondary (0-12) Administrative Planner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I int; If item 27 Is marked o Lanam Paul Ρ. Mary Murphy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 202 Green ST., Westernport, Maryland Ellen Comeau/ friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD. Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 12/05 permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State Flintstone, Maryland 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wayne 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Chronic congestive heart failure months /Medical Due to (or as a consequence of): **Examiner** Coronary artery heart disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown þ Part II. Dther significent conditions contributing to death but not résulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 page 2 1 ☐ Yes Division of Vital To the Hospitel or Attending Physiclen: within 24 hours after death. 25. Was case referred to medical examiner?

XYes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \substitute Nursing Home Hospital: 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) ij 2 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 09157 Dec 2 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D. Dpty Med Ex 124 W 3rd St Cumberland MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/200

ORIGINAL

			1- State of Maryland / De State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygiene Reg. No	11115 411476
	División de la constante de la		Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
	Physici /Medio		Margie Lee Munn		11/22/200	05 11:25 AM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
			2515 Ann Arbor Lane	Bowie // If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Georges
	Funeral		5. Social Security Number 4.55-22-6862 6. Sex 1 M 2 P F 83 7. Age (In yrs. last birthda	Months Days Hours Min.	10/10/1922	9. Birthplace (State or Foreign Country) Texas
	Director		Usual Residence of Decedent			201100
	yland		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	a-f a	cto	Maryland Prince Georges Bowie			1 XYes 2 No
	라 B 2 8	Director	10e. Street and Number	10f. Zip Code		itizen of What Country?
	death with the Maryland ome 23e or 28e-f show	rai	2515 Ann Arbor Lane	20716	USA	14. Race - American Indian.
	be filed within 72 hours after death with the Marylan hal Hygiene. Id other then "neturel", or freme 23e or 28e-1 show event, the Medical Exant her must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	o Rican, etc.)	Black, White, etc. Specify: White
ş	2 hou		15 Decedent's Education 16a Dec	edent's Usual Occupation	16b. k	Cind of Business/Industry
21215-0036	within 72 liene.	Completed	(Specify only highest grade completed) (Gi	e kind of work done during most of wor DO NOT use retired)		
7	giene giene	E	12 Home	Maker		n Home
yland	al Hy d oth	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Maider	_
<u>X</u>	Meni Meni Meni Meni Meni Meni Meni Meni	မ	Hiram William Grant, Sr.		Mae Richard	
Mar	and I sh			ling Address (Street and Number or Ru 5 Ann Arbor Lane B		
e,	jes 1 and 2 should be filed within 7 of Heelih and Mental Hygiene. If Item 27 is marked other then "n or other traumatic event, Ita Mad		20a Method of Disposition 20b. Place of Dis	position (Name of		ocation - City or Town, State
פֿ	ages nt of nor or		1 XBurial 2 Cremation 3 Removal from State	ematory or other place)		ittier, CA
Бант	permit. Pages 1 Depertment of H Important: If Ite any injury or ot		4 Donation 5 Other (Specify) Rose Hill 21. Signature of Fineral Service Licensee	22. Name and Address of Facility Ro		
ă	Depermination of the service of the) LAX	16000 Annapolis Ro		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not described the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CVA Due to (or as a consequence of): B. Hypertension Due to (or as a consequence of):	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death 11 Days
8/60,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
O. BOX 6	thet the death certifi led by the attending detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
as, r	8 0 0	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? One 3 Probably 4 Dunknown
Hecord	elaw hasb	Completed			24a. Was an autopsy performed? 1 □ Yes 2X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
VIII A	sicism: The certificate rrector, pag	Be (25. Was case referred to medical examiner?		th (Check only one)	
5	Physic this c	ျ	1 Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpat		ome SCXResidence 28d. Describe how inju	
	ding P. h. After funera	- Lo	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe now inju	ry occurred
DIVISION	ten for:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, de (Check only one) 1 Cartifying Physician: To the best of my knowledge, de (Check only one)	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	i) and manner as stated. id place, and due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifor	29c. License number	/	ate signed (Month, Day, Year)
			you chan of orgin	44 D 2143	8 N	01 22 2000
			30. Name and address of person who completed cause of death (Item 23a) (Type		MD 01/01	
			Michael J. LaPenta, MD, 445 Defense 31. Date filed (Mogrit, Day, Year), 32. Registrar's Signature	Highway Annapolis	, MD 21401	
	Sta Registr		31. Date filed (North, Day Year) 32. Registrar's Signature	nether a second		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Dav Month **Physician** 5:30 PM ALICE TEAR MAHAFFEY November 28, 2005 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Nursing & Rehab. Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yee Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 F 81 273-20-0172 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f ehow Examiner must be notified at Md. Montgomery Washington Grove 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 405 Brown Street Items 23a 20880 United States death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Administrator Private School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alton Edward Tear Loretta Siccardi ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alton Ghrist (Son) 403 Brown Street Washington Grove, Md. 20880 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Nov. 30, Alexandria, Va. Metropolitan Crem. * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, Md. 20877 (1) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia resulting in death) /Medical Due to (or as a consequence of) **Examiner** Multiple Cerebral Vascular Infarcts Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ner or Attending Physician: The law requires that the death certificate be executed burial-transit Exam Diabetes Mellitus the attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Malnutrition use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 X Unknown Completed been 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To this funeral 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 X Natural To the Hospitel or Attentories within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of curtifie 29c. License numbe D55054 November 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Dr. Attan Kasid M.D.

2005

31. Date filed (Month, Day, Year)

Rockville, Md. 20855

17519 Redland Road

32 Registrar's Signature

			For State Registrar	5	State o	of Marylar	•			ealth a Death	ınd M	ental Hy	giene Reg. No.	095	40430	
₩:	The state of	ê	1. Decedent's Name (First, Middle	, Last)								2. Date of De	ath Day	Year	3. Time of Death	
**	Physicia /Medic	_	Georgia			Louise		Мує	rs			11	30	05	14:30 PM	
	Examin		4a. Facility Name (If not institution,	give stre	et and nu	mber)		1		Location o			A .	unty of Death	. 1	
D.				ART	Ho	ATIGS				serla				llegan	•	
	Funeral		,	6. Sex	1 2 ∑) F	7. Age (In yrs.	last birthday) Yrs.	Months Months	r 1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da		9. Birth	place (State or Foreigr ntry)	7
5	Director		215-20-5350 Usual Residence of Decedent			82	115.					06/11/1	923	Mary	land	
	and .w.		10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits	
	Aany!	ō	MD A11	.egany				Cuml	erlan	d					1∏Yes 2 ☐ No	
	the t	Director	10e. Street and Number	-07					p Code				10g. Citizer	of What Cou	ntry?	_
	with Sa or	ā	518 Washingt	on St	root				21	502				USA		
	hours after death with the Maryland tural', or Itema 23a or 28a-f show at Examinar must be motified at	Funerai	11. Marital Status		. Was Dec	edent Ever in U	I.S. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)	o- 14.	Race - Amer		
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m O	al', o	by	3 X Widowed 4 ☐ Divorced		If Yes, G Year or [ve Dates:		1 🗌 Yes	21XI NO	Specify:			Sp	ecify: Wh:	ite	
2-003	n 72 hours after death with the Marylan "natural", or Itema 23a or 28a-f show salical Examinar must be notified at	Completed	15. Decedent (Specify only highes	's Educa	tion completed		16a. Dece	kind of wi	ork done d	during most	of worki	ng	16b. Kind	of Business/Ir	ndustry	
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altimore,	00		1 X Burial 2 ☐ Cremation		noval from	State	cemetery, cre	matory or	other plac							
ti Ti	t. Partmentant		4 Donation 5 Other (Sp			Res	tlawn Me			lens 1				e, Mary		_
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oʻ	exec an an rial-tr		resulting in death) Last		Due to	(or as a conse	quence of):	115	TAP	7	11.					
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Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	230	1 Live	utcome of pregn birth 2 ☐ Fet	al death 3[]Ectopic p		,			23d	. Date of deli-	very Day Year	
		sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4∐Preg 9∐Unki	nant at time of	death 5[Other (s	specify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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ŝ	The law requires thet the ate has been signed by the page 2 should be detache	5	Acute Ro.	1 - 6	2/2	fore	- 1	104	Soli	<i>-</i>	1.5	10	Yes 2□N	No 3□Pro	bably 4 Munknown	1
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₹	ysician: The is certificate hadinector, page	Be	25. Was case referred to medical examiner?		spital:	Inpatient 2	ER/Outpatie	at 3 🗆 n	Oth	05		me 5 ☐ Res		Other (Spec		
ō	Phys rthis ral di	. To	1 Yes 3.7 No	-	28a. Date	of Injury	28b. Time o		28c. Injur Wor			28d. Describe			ny)	_
o	iding F th. : After funer	tior	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		(Mo	nth, Day Year)	Injury	М		k? Yes 2 🔲	No					
Division of Vital	f or Attendi after death. Director: A I in by the fu	ifica	3 Suicide 6 Could i		28e. Plac	e of Injury - At I	nome, farm, st	reet, facto	ry, office			28f. Location	(Street and N	lumber or Ru	ral Route Number,	-
Ó	s after s after si Direct	Certification:	4 Homicide		Dun	Jing, etc. (Spec	ny)					Only of 70	mi, Olaley			Ÿ
	hour uner uner					e best of my kn										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medicai	one)			nner stated.			9c. Licens					igned (Month		
	Mil To	-	29b. Signature and title of certifie	1	1			2	D I) _ []				1 /		
	5		401	0	re	a n	17	D.:	UK	SWU				30/0	· •	
	nas		30. Name and address of person	who com	preted cau	use of death (Ite	m 23a) (Type		isr	ROC	id	cumb	eria	id. M	ID 21508	7
	≤ Sta	ato	31. Date filed (Month Day Year)	Jul	32.	Registrar's Sign		V V C				3 - 11 / 4		, , ,		_
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		•	1 - For State Registrar	State of Mar		artment of F		lental Hy	giene Reg2ND 05	40431		
	Physici		Decedent's Name (First, Middle, Last Irwin S. Muir	")				2. Date of De Month Decem	ber 01, 2005	3. Time of Death 01:33 PM M		
	/Medio		4a. Facility Name (If not institution, give	street and number)	<u> </u>		r Location of Death		4c. County of Dea			
1			24 Greenbriar Court	1-0	rostburg	0.0-10-40	Allegany					
	Funeral Director		5. Social Security Number 6. Security Number 17	X 2□F 7. Age ((In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Year) 12-Oct-1919 9. Birthplace (State or Foreign Country) Maryland				
	and w		Usual Residence of Decedent 10a. State 10b. County] 1	10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryi a-f sho	tor	Maryland Allegan	y F	Frostburg					1 Yes 2 □ No		
	vith the	Funeral Director	10e. Street and Number 24 Greenb	riar Court		10f. Zip Code			10g. Citizen of What Co	ountry?		
	ns 23e	erai	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	21532- Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	U.S.A.			
98	72 hours after death with the Maryland natural', or Items 23a or 28e-f show frai Examinar must be matted at	y Fun	1 Never Married 2 Married	Armed Forces? ↑▼Yes 2 No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2∭XNo	an, Mexican, Puerto Specify:	Rican, etc.)				
21215-0036	2 hours	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi		16a. Dece	dent's Usual Occup	ation		Specify: Whit	C Industry		
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	life.	DO NOT use retired	during most of work d)	ing	tire manufactu	ror		
d 21	filed w Hygier ther th	Cor	12 0 17. Father's Name (First, Middle, Last)		tire bu	lider	18. Mother's Nam	e (First, Middle	, Maiden Sumame)	II CI		
/lan	2 should be filed within 72 hours after dea and Mental Hyglene. Is marked other than "natural", or liems aumatic event, II's Medical Examination.	To Be	James Muir				Agnes Wal	lker				
Maryland	d 2 sho		19a. Informant's Name/Relationship (7) Daniel Muir	урв, Print) SON		ng Address <i>(Street .</i> h lund Ave .		al Route Numb berland	er, City or Town, State, . Maryland	Zip Code) 21502		
	f Healt item 2 other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	! !	Date	20c. Location - City or			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show amportant: If item 27 is marked other than "natural" or items 23a or 28a-f show appropriately injury or other traumatic event, the McCloal Examinational Denotating at ance.		1/SuBurial 2 □ Cremation 3 □ 1/SuBurial 2 □ Cremation 3 □)	Frostburg Me	emorial Park	05-Г	ec-2005 I	rostburg Mai	yland		
Ball	permit Depart Import any in		21. Signature of Funeral Service Licens	Durd		2. Name and Address Durst Funer		Frost A	ve., Frostburg,	MID 215		
	Physician /Medical Examiner	16	23a. Party Enter the disease, or comp spock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a			yo M YOF		,	Approximate Interval Between Onset and Death		
,8760,	eath certificate be executed attending physician and for use as the burial-transit	dicai Examiner	rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):			Re	African de la companya dela companya dela compa	Arc & 2005		
O. Bc	the d	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,	<u> </u>	23d. Date of del Month	ivery Day Year		
rds, P.	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant conditions co	entributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco use contribute to Yes 2☑No 3□Pr	o the cause of death?		
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Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	-5	Oth	26. Place of Deat	/				
n of	ng Phy fter this ineral c	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		28c. Injun Worl	v at		dence 6 □Other (Spe how injury occurred	cify)		
Divis	al or Attending F s after death. al Director: After ad in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	eet, factory, office		28f. Location (City or To	Street and Number or Ru wn, State)	Iral Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai			xamination and/or in				cause(s) and manner as date and place, and due			
	To t Withi To tl	M	29b. Signature and title of certifier	mo		29c. License	e number		29d. Date signed (Month	h, Day, Year)		
	7		30. Name and wrest of person who of	ompleted cause of dea	ith (Item 23a) (Type.	Print)	2011	7.1.10	B. M. A.	2,2005		
	MAN		VIRGINIA MARGE	2105, M	912 82	50N 1	Mut	com	THICAN	1 14/2/101		
	Sta Registi	_	31. Date filed (Month, Day, New) 200	32. Kegistrar	s Signatula	certai						

		•	For State Registrar	Sta	ite of Ma	aryland		artmen rtificate				ental Hy	giene Reg. Nö		40432
			1. Decedent's Name (First, Midd	le, Last)								2. Date of De. Month	ath Da	y Year	3. Time of Death
	Physici /Medic		Paul		Lawre	nce		Mille	r			DECEMBE		2005	0250 M
	Examin		4a. Facility Name (If not institution	n, give street a	and number)			4b. City,	Town, or	Location	of Death		4c.	. County of Deat	th
A	*		MEMORIAL HOSP	-	7.4-	a /la cua la	ne bioboout		1BERI		r 24 Hrs	9 Date of Bird	b	ALLEGAN	
	Funeral Director		5. Social Security Number 218-12-5879	6. Sex 1 (X) M 2		ө (in yrs. та В1	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 11/09/192	y, Year)		hplace (State or Foreign buntry) Land
	N	ł	Usual Residence of Decedent									11/07/17/	4	rially	Tanu
	ehow		10a. State 10b. County			10c. City	, Town or Lo								10d. Inside City Limits
	8e-f	cto	MD Alleg	a n y 			Cumber								1∭ Yes 2 □ No
	or 28e-f	Director	10e. Street and Number					10f. Zip					10g. Cit	tizen of What Co	ountry?
	s 23s	Ta l	829 Columbia		is Decedent	Ever in 11 C	12.1		21502		signa /Spa	ofy Voc or No		USA 14. Race - Ame	nican Indian
	item de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Arr	ned Forces?		_ 13.	If Yes, spec	offy Cubar	n, Mexica	ın, Puerto	ecify Yes or No Rican, etc.)	•	Black, Whit	
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21	within within the the with the within the wi	면 면	Elementary/Secondary (0-12)		llege (1-4or 5	5+)	life.	DO NOT us	e retired)	,		-			
21	filed w Hygier other th		11 17. Father's Name (First, Middle	(ant)			D	river		19 Moth	ar's Name	(First, Middle,		Beverage	
and	ntal H od of	Be				Mille	25			Ann			1.	Cond	lon
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other then "nature or other traumatic event, Its Madical	ပို	John A 19a, Informant's Name/Relation	nthony ship (Type, Pri	int)	111111		ng Address	(Street a					or Town, State, a	
≅	and 2 s lealth ar m 27 io		Rosemary Scarpell				9 Ros	ger Way	y, Lav	/ale,	Mary1	and 2150)2		
ē,	of Hea of Hea fitem		20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Nan	ne of			ate	20c. Le	ocation - City or	Town, State
Ë	Pages nent of I int: if its iry or o		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (al from State		et Memo				12/03/	2005	Cumi	berland,	Ma r yland
Baltimore,	permit. Pages t and Department of Health Important: if item 27 eny injury or other tr once.		21. Signature of Funeral Service	Licensee		<i>,</i>							-	neral Homo	•
<u> </u>	8258		of wheat C	Mas	ne									ryland 2	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complication: t only one cau:	s that caused se on each li	the death ne.	. Do not ent	er the mod	e of dying	, such a	s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
W. 16.	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a		sis-Fu									Days
	/Medical Examiner		resulting in death)		Due to (or as	•									
		9	Sequentially list conditions, if any, leading to immediate	b	Cerebr		lar Acc	ident							
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ó	exec an an	Exa	resulting in death) Last	C	Due to (or as	a consequ	ence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d											
9	death certifica attending ph	Med	IF FEMALE:	90 1/											
Вох	ath ca	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1.	res, outcome]Live birth]Pregnant at	2 Fetal	death 3	Ectopic pr						23d. Date of del Month	ivery Day Year
	that the de ad by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown	ume or de	atti 5[⊥Otnei (sp	ecity)						
P.0	res that the igned by be detact		Part II. Other significant condit	ons contributi	ng to death b	ut not resu	Iting in the u	nderlying c	ause give	n in Part	1.	23e. Did t	obacco (use contribute to	the cause of death?
rds	quires n sigr	d by	Myocardia	1 Infarc	tion, C	ongest	ive Hea	rt Fai	lure			10	res 2	□No 3∏Pr	robably 4 ∐Unknown
00	s been s should	olete	Non-hodgl		,	Ü						24a. Was		24b. Were au	utopsy findings available
of Vital Records,	The lay te has	Completed	Non-nough	carr s riyn	ipriona —							autor perfo	rmed? 2⊠No	death?	completion of cause of
ita	ysician: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?	al .						26. Plac	e of Death	(Check only o			
<u>}</u>	hysice his ce	To	1 ☐ Yes 2 🖔 No	Hospita	1 M Inpatie		R/Outpatier							6 □Other (Spe	cify)
n	ding Ph h. After th funeral	on:	27. Manner of Death 1 XNatural 5 ☐ Pends	'9'	. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		8c. Injury Work			28d. Describe !	now inju	ry occurred	
Division	ttend death stor: / the f	Certification:	3 Suicide 6 ☐ Could	not be	Place of Ini	unc - At hor	me farm str	M factor		es 2 [28f Location /	Street ar	nd Number or Ri	ural Route Number,
Di∨	after Direction by	ertif	4 Homicide deter	nined	. Place of Inj building, et	c. (Specify,)	coi, raciory	, once			City or Tov			rar route range,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funarel Director: After this certifics completely filled in by the funeral director,) and manner as	
	n 24 ł	Medical	(Check only 2 Medica one)		n the basis of nd manner sta		on and/or in	vestigation	, in my op	inion, de	ath occurr	ed at the time,	date and	d place, and due	to the cause(s)
	To the withing To the company	Σ	29b. Signature and little of certifi	er	^			290	. License	number			29d. Da	te signed (Mont	h, Day, Year)
) /	O/IVA		Durch	m	a t	fen	~~~)5441	.1			DECE	EMBER 2	, 2005
	,		30. Name and address of person						CID	יחים כו)	AND	MD 2150	2		
200	MGA Sta	ta	BEVERLY CALKIN 31. Date filed (Month, Day, Year)	500 I		IAL AV		CUP.	IDEKL	I e UNIERI	MD 2150			
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				State of Ma	aryland	-	artment of <i>rtificate c</i>	Health and If Death	Mental Hy	/giene Reg?Nd.	5 4	01.	3 3
T			1. Decedent's Name (First, Middle, La	ist)					2. Date of D	eath	Vana	3. Time of	f Death
	Physicia	_	Helen	Mason	n		Meist	er	Month Decembe	Day r 2, 2005	Year	2:00 /	AM
	/Medic Examin		4e Fecility Neme (If not institution, gi	re street end number)				4b. City, Town, or	Location of Dea				
		•	Devlin Manor Heal	th Care Cente	er			Cumber	land	A1	1egany		
	Funeral				e (In yrs. les		If Under 1 Ye					ace (State o	or Foreign
	Director		216-66-1113	1□M 2XIF	39	Yrs.			11/25/1		Maryl		
	p >		Usual Residence of Decedent		10c. City, T	fown or L	ocation				16	Od. Inside C	ity Limits
	show	-	10a. State 10b. County		TOC. City, I								21☑ No
	Me Me Me Me Me Me Me Me Me Me Me Me Me M	Director	MD Allega	ny		Cun	berland			10g. Citizen of V	Mhat Coup		
	vith ti	吉	10e. Street and Number				10f. Zip Cod				Vital Court	ıy:	
	is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the sith and Mental Hygiene. Other It marked other then "neture!, or items 23a or 28a-f show other traumatic event, I'm Medical Examinat must be notified at	Funeral	11705 Bedford	Road, NE	Ever in II S	12	Was Decedent	21502	Specify Ves or N	USA 14 Bac	e - America	an Indian.	
	item item	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		13.	If Yes, specify C	of Hispenic Origin? (uban, Mexican, Pue	rto Rican, etc.)	Blac	ck, White, e		
0020	rs aft	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•0		1 □ Yes 2 🗓 I	lo <i>Specify:</i>		Specify	<i>'</i> : 1	√hite	
ξ	ture		15. Decedent's E	ducation	1	I6a. Dece	dent's Usual Oc	cupation		16b. Kind of Bu			
<u> </u>	n "ne	Completed	(Specify only highest gr	ade completed) College (1-4or 5		(Give life.	kind of work do DO NOT use re	ne during most of wo ired)	orking				
7	the iene		Elementary/Secondary (0-12)	College (1-401 5	+)		Homema	ker		Home	3		
2	Hyg other	Bec	17. Father's Name (First, Middle, Las)				18. Mother's Na	me (First, Middle	e, Maiden Suman	ie)		
and	ld be lental ked o	10 B	Hervey	W.	Sh	uck		Mary	F	earl	Gell	nausen	
	shour nd N mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Str	eet and Number or F	rurel Route Numi	ber, City or Town,	State, Zip	Code)	
Ě	odith e 27 is		Carol A. Carpenter /	daughter		1612	Tweed St	reet, Rockvi	lle, MD	20851			
ē,	es 1 and 2 of Health of Health litem 27 is r other tra	-	20a. Method of Disposition	Ü	20b. Plac	e of Dispo	osition (Name of matory or other	place)	Date	20c. Location -	City or To	wn, State	
2	Pages nent of int: if its iry or o		1 ☐ Burial 2 🖾 Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci				d Cremato		03/2005	Cumberla	and. Ma	rvland	I
Dallino	보투뿐층 .	ŀ	21. Signature of Funeral Service Lice	nsee				dress of Facility Ac					<u>. </u>
ŏ	Deperiment impo	İ	1 Lint C	adone				atur Street,					
			23a. Part1. Enter the disease, or con	polications that caused	the death.	Do not en	ter the mode of	dying, such as cardia	c or respiratory	arrest,		Approximat Interval Bet	te
	Dhyoician		shock, or heart failure. List only	one cause on each lir	ne.						į	Onset and	Death
)	Physician 	- 1	Immediate Cause (Final		1.		2080				1	MIA	~
	Examiner		disease or condition resulting in death)	a	Due to (or a						1 -	7	
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	The I	ĕ							1 🗆	Yes 2⊞No	1 🗆]Yes 2□] No
	len: rtifics ctor, I	Be	25. Was case referred to medical examiner?			-10		26. Place of De	eath (Check only	one)			
>	Physicien: r this certific rral director,	2	1 Yes 2⊒ No	Hospital: 1 ☐ Inpatie	nt 2 EF	VOutpatie	III 3LI DUA	***	Home 5□Res	idence 6 □Oth	er (Specify	<i>)</i>	
	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		Bb. Time o		njury at Work?	28d. Describe	how injury occur	red		
DIVISION	Attending I ar death. ector: After by the funer	atic	2 ☐ Accident investigation					Yes 2 No					
Ž	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At home c. (Specify)	e, fam, st	reet, factory, offi	ce		(Street and Numb own, State)	er or Hure	Houte Nun	nber,
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	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours electricated within 24 hours electricated within 24 hours electricated and the completely filled in by the funeral director, page 2 should be deteched for use as completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exe	nysician: To the best of miner: On the basis of	examination	edge, deat n and/or in	n occurred at the vestigation, in m	e time, date and plac ly opinion, death occ	e, and due to the urred at the time	e cause(s) and ma e, date and place,	inner as stand due to	ated. the cause(:	s)
	the the l	Med	one) 29b. Signature and title of certifier	and manner sta	nea.		29c l in	ense number		29d. Date signe	d (Month.)	Day, Year)	
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	2					0-1/7		COC 1		Decembe	:L Z9 Z	.000	
	MRS		30. Name and address of person who					Highran I	oVolo Mos	orland 21	502		
س				Bollino, Jr.	ar's Signatur			ingiway, L	avare, man	ryland 21	JUZ		
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RE	LL L MA	KS.	Please Type or Print in Black In State of Maryland / Department		lental Hygi	_	40434
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Everett Layton Marshall, Jr.		2. Date of Death	R [™] 25, 2005	3. Time of Death 6:29 P M
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 29940 THREE NOTCH ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-42-5179 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day,	4c. County of Death ST MARYS 9. Births Cour 3, 1942 M	CO place (State or Foreign try) arvland
	h the Maryland or 28e-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland St. Mary's Mechani 10e. Street and Number	ocation			0d. Inside City Limits 1 ☐ Yes 2X No
980	permit. Pages 1 end 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Iteme 23a or 28e-f ehow eny Injury or other traumatic event, the Medical Examinar must be mutified at 000ce.	by Funeral	38310 Golden Beach Rd. 11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	20659 Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No-	U S A 14. Race - Americ Black, White, Specify: wh	
Maryland 21215-0036	iled within 72 h tygiene. ther than "netu nt, the Medical	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation of kind of work done during most of work DO NOT use retired) k Mechanic	ing	Sb. Kind of Business/In Automotive	dustry
arylanc	should be fand Mental Hand Mental Handwarked of	To Be	Everett Layton Marshall, Sr.	Harriet	t Graves		Code)
Baltimore, M	t. Pages 1 end 2 rtment of Health . rtent: If Item 27 i njury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposements, cre 2rinsfiel	Chandler Dr. N., osition (Name of matory or other place) Nov. d-Echols Crematory 2. Name and Address of Facility Brid	30°, 2005 2	Charlott	e Hall,2062
Bal	Depa Impo Impo eny Ir		M00641 P	.A., 30195 Three N	Notch Rd.	, Charlotte	eral Home, e Hall, MD Approximate 20622 Interval Between
,1200	Physician /Medical Examiner physicien and physicien and physicien and street physicien and street physicien and ph	Ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C	tri Godowan	er Dise	Pase	Onset and Death
.O. Box 687	ath certif ritending or use a:	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
٥.	w requires that the de been signed by the e should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		2 No 3 Prob	pably 4 Unknown
of Vital Records,	The ete h page	Be Completed	25. Was case referred to medical examiner? Hospital: Hospital:	Other	autopsy perform	ed? death?	SCENE
Division of	fune After	Certification: To	27. Manner of Death 27. Manner of Death 1	of 28c. Injury at Work? M 1 Yes 2 No	ome 5 ☐ Resider 28d. Describe how 28f. Location (Stre	v injury occurred	77
ā	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a Certifier 1 Certifying Physician: To the basis of examination and/or in			isa(s) and manner as s	
)	To the within 2 To the complel	Medical	29b. Signature and title of certifier	29c. License number O C M E		d Date signed (Month, OVEMBER 26,	
5	085 sta	ite		111 PENN STREET, I	BALTIMORE	, MARYLAND,	21201
DH	Regist	rar	31. Date filed (Month, Day, Year) NOV 3 0 2005 32. Registrar's Signature	Grade			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Adalaine Edna Mc Carthy November 25, 2005 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26948 Cox Drive Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours 578-20-6770 89 7, 1916 Washington, DC Director Usual Residence of Decedent death with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26948 Cox Drive 20659 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Deperment of Health and Menial Hygiene. Important: if Item 27 is marked other then "ne eny injury or other traumatic event, the Music 2006. Elementary/Secondary (0-12) Coltege (1-4or 5+) Secretary Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oscar Elwood Estep Edna Margaret Lusby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26948 Cox Drive, Mechanicsville, MD 20659
Date 20c. Location - City or Town, State Robert L. Brumback/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 XBurial 2 ☐ Cremation 3 ☐ Removat from State Cedar Hill Cemetery 20, 2005 Suitland, Maryland 4 ☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility Brinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licensee P.A., 30195 Three Notch Rd., Charlotte Hall, MD wen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximat 20622 Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician Failure To Thrive /Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) sate has been signed by the attending physicien page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12-months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: nin 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ို 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Acolist D35295 November 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satish Jumani, 10 St. Patricks Drive, Waldorf, MD 20603 31. Date filed (Month, Day, Year) State NOV 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 🕦 🗍 🖔 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 28, 2005 **Physician** NANCY ELIZABETH MYERS 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON PRINCE GEORGES FORT WASHINGTON HEALTH & REHABILITATION CIR. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 17, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ☐ M 2 🛱 F MARYLAND 212-76-0315 Director 75 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ¥Yes 2 □ No Director MARYLAND CHARLES BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2693 MARSHALL HALL ROAD 20616 UNITED STATES or items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No þ Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 2ND. GRADE CLERK PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FREDERICK DOUGLAS MYERS SARAH MATILDA NEALE MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. 3410 METROPOLITAN CHURCH ROAD, INDIAN HEAD, MD 20640 GIRARD W. MYERS / BROTHER 20a. Method of Disposition
1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State METROPOLITIAN U.M. CHURCH CEM. DEC.2,2005 INDIAN HEAD, MARYLAND ^¹ 4 □ Donation 5 □ Other (Specify) 21. S. ature of Funeral S. 300 Licept 16 Licept 16 Licept 16 MOO583 THORNION FUNERAL HOME, P.A 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on yetch line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit Due to (or as a consequence of nding physician P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2∏ No 1 🗌 Yes 2 🗖 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 410 ို 1 ∐ Yeyé 2 🗹 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Man er of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After Injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Coux not be devermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of willifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAXIMA BERWA, M.D. 7700 OLD BRANCH AVENUE, SUITE #101, CLINTON, MARYLAND 31. Date filed (Month, Day, Year) NOV 3 0 2005 State Registrar

			1 For State	State of Maryla	and / Depa	artment of H	lealth and	Mental Hy		•		1 01	O ~~
			Registrar		Cei	rtificate of	Death		Reg. No.	UUU)	4 1 4	3/
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De. Month	Day	/Ye	ar_	3. Time o	
	/Media		Stanley P. Neslin					Novemb			لسسيج	2:05	рм
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, o		ath		County of (
			Washington Advent			Takoma				ontgo			
	Funeral		5. Social Security Number 6. Sept 578–10–9870		rs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year)	1.8 W	Count	(VI	or Foreign
	Director		Usual Residence of Decedent		7, 110.	L		pane 20		10 14	asii.	ing co.	11, DC
	and T		10a. State 10b. County	10c.	City, Town or Lo	ocation					10	d. Inside C	City Limits
	Mary sho	ō	Maryland Montgom	erv S:	ilver Sp	ring						1 🗆 Yes	s 2 ∑No
	28a-	Directo	10e. Street and Number			10f. Zip Code			10a. Citi	izen of Wha	t Count	rv?	_
	with e or			-						USA		,	
	eath	Funeral	206 Whitestone Ro	ad 12. Was Decedent Ever in	U.S. 13.	20901 Was Decedent of H	lispanic Origin?	(Specify Yes or No		14. Race - /	America	n Indian,	
	ter of then	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ Ņo		If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		Black, V			
8	a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Oates:		1 ☐ Yes 21 No	Specify:			Specify: W	hit	>	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or terms 23e or 28e-f show event, the Mcotcal Examiner hast be notified at	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Ki	nd of Busin	ess/Ind	ustry	
212	7 4 4	be	(Specify only highest grade	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of w	vorking					
2	d with	Completed		4	Admi	nistrato:	r		Gov	ernme	nt		
פ	should be filed nd Mental Hygi marked other imatic event, i	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden	Sumame)			
<u> </u>	ould be Mental arked o	ToE	Louis Joseph Nesl	ine			Card	oline Ada	Moo	re			
Maryland	should and Men	15	19a. Informant's Name/Relationship (Ty	pe, Print)		17		Rural Route Numbe					
	s 1 and 2 should of Health and Men Item 27 te marke other traumatic	13	Lily M. Nesline/	Wife	206	Whitesto	ne Road,	, Silver	Spri	ng, M	D 2)901	
e e	of He of He f Item r oth	1	20a. Method of Disposition	20t	 Place of Dispo cemetery, crer 	sition (Name of matory or other plac	Dog	Date	20c. Lo	cation - City	or Tov	m, State	
Ĕ	permit. Pages Depertment of Important: If It any injury or o	. 1	1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	GILLOAD LIOU STATE		n Cremator	. 1000	ember 2, 2005	Alexa	ndria,	Vir	inia	
	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service License	90	F3	2. Name and Addre	ss of Facility	neral Home					
ñ	8858		James S	Japan				W,Silver Sp		MD 20	901		
	-		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de	eath. Do not ent	er the mode of dyin	ng, such as card	iac or respiratory ar	rest,			Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition	1-	11/	100						Onset and	Death
	/Medical		resulting in death)	Due to (or as a cons	sequence of):	y —							
	Examiner			1/100 6	2011	5							
	e for	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):								
	eath certificate be executed attending physicien and for use as the burial-transit	Examiner	trial initiated events	·									
o	en al en al		resulting in death) Last	Due to (or as a cons	equence of):								
3760	ate be nysici	cal		l		·-					-		
9	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:						-				
Вох	th ce tendi	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	,		2	23d. Date of		•	Vans
	ed fo	sici	in the past 12 months?	4☐Pregnant at time of 9☐ Unknown	of death 5	Other (specify)				Month		Day	Year
л О	at the de I by the stached	hy	9 Unknown										
ທົ	w requires that been signed be should be det	by	Part II. Other significant conditions con	thouting to death but not i	resulting in the ui	nderlying cause giv	en in Part I.			se contribut			
ecords,	s uen s	Completed						1 U Y	'es 21	9No 3	Proba	bly 4 🗍	Unknown
ပ္ထ	lawr as be 2 sh	ple						24a. Was autop		24b. Were	autop	sy findings	available cause of
ř	The law ate has page 2:)or						perfor		deati	n? Yes 2	□ No	
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	ne)				
>	Physician: this certific ral director.	ToE	1 Yes 2 No	lospital: 1 4 Inpatient 2	☐ ER/Outpatien	it 3 DOA Oth	er: 4 🗌 Nursing	Home 5 Resid	lence (Other (S	Specify)		
0	ig Pt ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe h	ow injun	occurred			
<u>o</u>	endir ath. or: Af	atlo	2 Accident investigation			M 1 🗆	Yes 2 ☐ No						
Division	rected by 1	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (S City or Tow			Rural	Route Nun	nber,
	rs aff	Cer											
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	cal	29a. Certifier 1 Certifying Phys (Check only 2 Medicat Examir	sician: To the best of my liner: On the basis of exam	nowledge, death	occurred at the tin	ne, date and pla- pinion, death oc	ce, and due to the coursed at the time.	ause(s)	and manner	r as sta	ted. he cause(:	s)
	To the h within 24 To the F complete	Medical	one)	and manner stated.									
	To To	2	29b. Signature and title of certifier			29c. Licensi	,			e signed (M			
•			1. (11/1/	11,1170		12%	2047	5	11.	29.	05		
	5		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)	1		-	2		1 ~	0-
			Jones E. Call	9 m	610 (aroll	Hit	Tillem	12	K,	1/k	1.0	1/2_
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	griature	marks 5							

			1 - For State of Maryland / Department of State of Maryland / Department / De	artment of Health and M	lental Hygie	
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	/Medi	cal	JOSEPH EDWARD NORWOOD, SR. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	NOVEMBER	
	Examir	ner	5015 GEN. ANDERSON COURT	SHARPSBURG		4c. County of Death WASHINGTON
ŀ	Funeral Director		5. Social Security Number $370-12-3077$ 6. Sex $1\times M$ 2 \square F 7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye DEC. 29,	9. Birthplace (State or Foreign Country) MICHIGAN
	anyland ehow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e-feh	ctor	MARYLAND WASHINGTON	SHARPSBURG		1X Yes 2 □ No
	with th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ter death Items 23	Funeral	5015 GEN. ANDERSON COURT 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A.
980	ours al	by	1 Never Married 2X Married 1 X Yes 2 No 1 9444-	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: WHITE
15-0	"netur	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	ing 16b	b. Kind of Business/Industry
212	filed withir I Hygiene. other then	ошо	Elementary/Secondary (0·12) College (1-4or 5+) 5+	DO NOT use retired) TEACHER	1	PUBLIC SCHOOLS
Maryland 21215-0036		BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	
ryla		70	CLARENCE E. NORWOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ELSIE F		
Ma	nd 2 s lith ar 27 is r treu		CECILIA F. NORWOOD, WIFE 5015	ng Address <i>(Street and Number or Rura</i> GEN. ANDERSON COU	JR T, SHA RI	ty or Town, State, Zip Code) PSBURG, MD 21782
Baltimore,	ges 1 a it of Hea		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place)	ate 20c	. Location - City or Town, State
ţi			`4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON	NAT. CEM. 12/06	5/2005 AR	RLINGTON, VIRGINIA
Bal	permit. Par Departmen Importent: any injury once.		Paul M. Dean	2. Name and Address of Facility BAST FUNERAL HOME	BOONSBORO	NATIONAL PIKE O, MARYLAND 21713
ı			Part 1. Enter the disease of complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	otic Cardia Va	scular ()iserse
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	ned Insit	Examiner	Sequentially list conditions, and the sequence of the sequence			
o,	an and		that initiated events c. Due to (or as a consequence of):			
8760,	ficate be executed physician and s the burial-transit	dicai	d			
9 xc	death certifica e attending ph id for use as th	lan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	***		23d. Date of delivery
.O. Box		Physicia	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year
<u> </u>	Se und	by Pi	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records	w require been si should b	eted	- Diahetes Mellitus - type	T	1 Tes	2 ☑No 3 ☐ Probably 4 ☐Unknown
al Rec	The tar ate has page 2	Completed			24a. Was an autopsy performed	
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EPt/Outpatien	26. Place of Death		
J of	ding Phys h. After this funeral di	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Hon	ne 5 Hesidence 8d. Describe how in	
Sio	Attending or death. ector: After by the fune	catlo	2 Accident investigation	M 1 Yes 2 No		
Division	tel or At s after d el Direct ed in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	et, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the f	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurre	nd due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To t withi To tl	M	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			Zdwarle La Hoth M.	10-1062	No	0.30,2008
3H	-11+1		30. Name and address of person who completed cause of death (Item 23a) (Typé, F EDWARD W. DITTO, III, M.D. 19011 ORC	Print) CHARD TERRACE ROAD,	. HAGERSTO	OWN. MD 21742
	Sta		31. Date filed (Month, Day, Year) - 32. Registrar's Signature		,	,
	Registr	ar	DEC 0 2 2005 Denem B. A.	sell		

						artment of Hea				10100
			1 - State Amend Item Registra Amend Item	s 10a,10b #10a-f&19	per FH/DVI a Per FH/	85191110	A AH	Rec	2005	40439
	Physici	an	1. Decedent's Name (First, Middle, La	NORTHCRA				Month	Day Year 29, 2005	3. Time of Death 10:13 A M
	/Medic Examin		LEONARD T. 4a. Facility Name (If not institution, given		<u>F</u> 1	4b. City, Town, or Lo		November	4c. County of Dea	
		# &	Memorial Hospita			Cumber1		9 Date of Birth	Allegar	
	Funeral Director			Gex 7.Ag 1 X 1M 2□F	e (In yrs. last birthday 85 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bit C	thplace (State or Foreign ountry) ST VIRGINIA
	pu *		Usual Residence of Decedent	Morgon-	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla	tor	West VA Hampshir		CUMBER	AND PAW I	PAW			- XX No
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "nature!, or itama 23a or 28a-f ehow event, the Medical Examinar must be notified at	Director		1, Box 15	9	10f. Zip Code		100	g. Citizen of What C	ountry?
	eath v	Funeral	15 CUMBERLAND ST	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispa	25434 anic Origin? (Spec	ofv Yes or No-	U.S.A.	erican Indian,
9	after d	Fun	1 Never Married 2 Married	Armed Forces?	No	Was Decedent of Hispa If Yes, specify Cuban, N		lican, etc.)	Black, Whi	te, etc.
Maryland 21215-0036	filed within 72 hours after Hygiene. Ather then "nature!, or ite ont, the Medical Examina	d by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	WWII		Specify:	146		WHITE
7	in 72 t	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occupation of kind of work done during DO NOT use retired)	on ing most of workin		6b. Kind of Business	Vindustry
212	giene grene er the	Com	Elementary/Secondary (0-12) 12	College (1-4or:		ICK MASON			CONSTRUC	CTION
and	be filed ntal Hygi ot other event, I	Be	17. Father's Name (First, Middle, Last				3. Mother's Name		aiden Sumame)	
Ĕ	d 2 should be th and Mental 7 is marked of traumatic ev	은	GUY A. NORTHCF 19a. Informant's Name/Relationship		19b. Mail	ing Address (Street and		LINE Route Number, (City or Town, State,	Zip Code)
	7.2 ± 2		GARY RORTHCE		RO	OUTE 1, BOX	294, HI	GH VIEW,	WV 2680	08
ore,	of He		20a. Method of Disposition 1 2 Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)			c. Location - City or	Town, State
Baltimore,	permit. Pages Department of I Importent: if it, any injury or o		4 □ Donation 5 □ Other (Special Service Lice			V CEMETERY		/2005	SLANESV]	ILLE, WV
Ba	perm Depa impo any i		Manal O	lenche	(ROL)	2. Name and Address of GIFFIN FULL P.O. BOX	NERAL HO	ME, INC.	E. WV 26	5711
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	the death. Do not er					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ctive Lur	na dis	ease		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		ı			
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ŏ	th cert lending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death 3	□Ectopic pregnancy			23d. Date of de	,
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be deteched for use as in	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown		Other (specify)			Month	Day Year
۵.	res thet the de signed by the e I be deteched f	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause given in	in Part I.	23e. Did toba	cco use contribute to	o the cause of death?
rds	w requires been sign should be	ed b						1 ☐ Yes	2 □ No 3 □ P	robably 4 Zunknown
eco	law re	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>e</u>	: The icete h			1				performe 1 Yes 2	death? ∃No 1 □ Yes	2 □ No
\frac{1}{5}	rsiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	Other	6. Place of Death 4 □ Nursing Hom		ce 6 □Other (Spe	ecify)
n of	ng Phy ter thii neral o	T:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da				8d. Describe how		
Sio	tendir Jeath. Ior: Al the fu	catle	2 Accident investigation 3 Suicide 6 Could not t	on			s 2 □ No	Of Leasting /Ctra	at and Number of B	and Route Musels
<u>></u>	efter of Direct Direct In by	Certification;	4 Homicide determined	289. Place of in	ury - At home, farm, s c. (Specify)	reet, factory, office	2	City or Town,	et and Number or R State)	urar Houte Number,
	To the Hospital or Attending Physician: The lav within 24 hours elter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2					th occurred at the time, onvestigation, in my opinion				
	the Hin 24 the Fi	Medical	one)	and manner st		29c. License nu			I. Date signed (Moni	
) (2 1 UA		29b. Signature and title of certifier	1			676			30,2W5
'	, , .		30. Name and address of person who	completed cause of o	leath (Item 23a) (Type			2		6
	nas		Dr. Vikramaditya	Popnai	924 Set	on Drive	Cumbe	rland, s	Maryland	21502
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	41			•	

			1 - For State Registrar	State of Maryland /	Depa		t of H	ealth a				05	40440
н	Physic	ian	1. Decedent's Name (First, Middle, Last)						1	2. Date of Dea Month		Year	3. Time of Death
	/Medi		Elmer Hugh Ore							ecembe		2005	12:45 A M
1	Exami	ner	4a. Facility Name (If not institution, give si	reet and number)				Location of	f Death		4c. Cou	inty of Death	
ļ.,			260B Foxtown Road 5. Social Security Number 6. Sex	7 4 (1 (Elak (.)		ident		2411			rrett	
	Funeral Director			7. Age (In yrs. last) M 2□ F 87	Yrs.	If Under Months	Days	If Under 2 Hours		B. Date of Birth (Month, Day)	1918	9. Birth Con Mary	nplace (State or Foreign untry) Land
	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itams 23a or 28a-f show int, the Medical Examinat rust be notified at		10a. State 10b. County	10c. City, To	own or Lo	cation							10d. Inside City Limits
	the Marylar 28a-f show notified at	Ď	Maryland Garrett	Acc.	ident	-						-	1 □ Yes 2 No
	r 288	Directo	10e. Street and Number			10f. Zip (Code			1	0g. Citizen	of What Cou	untry?
	ath with 23a or	ai Ω	260 B Foxtown Road			2152	20				USA		,-
	deat	Funerai		2. Was Decedent Ever in U.S.	13. V			panic Orig	in? (Speci	ify Yes or No- can, etc.)	14. F	ace - Amer	
9	after or Ite	臣	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give		r Yes, specr I□ Yes 2			Puerto Ri	can, etc.)		Black, White	, etc.
8	'72 hours after dea "natural", or Itams idical Examinal di	d b	3 Widowed 4 Divorced	Year or Dates:		ILITES 2	LANO	Specify:			Spe	nc <i>ify:</i> W	hite
21215-0036	nati	Completed by	15. Decedent's Educi (Specify only highest grade	ation 16 completed)	Sa. Deced (Give	lent's Usual kind of work OO NOT use	Occupat k done du	tion uring most	of working	,	16b. Kind o	f Business/li	ndustry
121	within ene. then	m	Elementary/Secondary (0-12)	College (1-4or 5+)	_		e retired)						_
7	e filed within the Hygiene. other then vent, the M		17. Father's Name (First, Middle, Last)		Sawy	<i>r</i> er		10 Marks	to Nome - (First 18:44 4		-	afters
an(ould be to Mental I Marked or Maric eva	Be.	_							First, Middle, M		iame)	
Ξ	should be ind Menta i marked i marked	2	Solomon Orendorf 19a. Informant's Name/Relationship (Type)	2 Orint)	Ob. Mailie		(0)			rennema			
Maryland	2 E 8 E	1 8	Viola M. Orendorf/w							Route Number,			p Code)
Ġ,	s 1 and 3 f Health itam 27 other tra		20a. Method of Disposition						, ACC	ident,		21520 in - City or T	our State
Baltimore,	0 0		1 Burial 2 □ Cremation 3 □ Re	20b. Place cemel				- 1					
Ē			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licenses	Bittir	iger	Ceme	tery	Dec	c. 7,	2005 E	Bittir	ger,	Maryland
Ba	permit. Departr Importa any inj		NA XIO.	man									
			23a. Part1. Enter the disease, or complica	ations that caused the death. Do	P. not ente	O. Bo	$\times 27$	5, Gr	cants	ville,	MD 2	21536	Approximate
н	Discontinuo		shock, or Neart failure. List only one Immediate Cause (Final	cause on each line.	1	a tilo illogo	or dymig,	30011 23 00	ardiac or r	espiratory arre	151,		Interval Between Onset and Death
н	Physician /Medical		disease or condition resulting in death)	Le men	115	_							yeurs
	Examiner			Due to (or as a consequence	e of):								0
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):								
	uted d ansit	Examiner											
ó	exec an an rial-tr		resulting in death) Last	Due to (or as a consequence	e of):								
8760	death certificate be executed e attending physician and id for use as the burial-transit	ical	L d										
9	ng ph as th	Ned	IC CCMAIC.										
Вох	feath certifica attending pl	an/h	200. Was decedent pregnant	. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3∏6	Ectopic preg	nnancy.				23d. [Date of delive	ery
		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 9 Unknown		Other (spec						Month	Day Year
P.O.	that the de led by the a detached f	Physician/Med	9 Unknown						_				
	8 5 8	þ	Part II. Other significant conditions contri	buting to death but not resulting	in the und	derlying cau	ise given	in Part I.		23e. Did toba	acco use co	ntribute to the	he cause of death?
Vital Records,	w require been signature	Completed							[1 🗆 Yes	s 2□No	3 🗆 Prot	pably 4 hknown
e Č	has bo	ple								24a. Was an autopsy		. Were auto	psy findings available mpletion of cause of
<u>د</u>	The ate ha	50								perform	ed2 No	death?	2□ No
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?				. 2	6. Place of	f Death (C	heck only one			
_	Attanding Physician: r death. sctor: After this certific. by the funeral director.	2	1 ☐ Yes 2 ☐ No	spital: 1 ☐ Inpatient 2 ☐ ER/O				4 INUIS	ing Home	5. Resider	nce 6 🗆 O	ther (Specif	y)
Ē	ing P	 	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	280	. Injury a Work?	t	28d	. Describe how	v injury occi	urred	
. <u>S</u>	ttand death stor: /	cati	2 Accident investigation 3 Suicide 6 Could not be			М		s 2 No					
Division of	l or At after of Direct J in by	Certification:	4 Homicide determined	 Place of Injury - At home, f building, etc. (Specify) 	arm, stree	et, factory, o	office		28f.	Location (Stre City or Town,	et and Nun State)	nber or Rura	l Route Number,
_	pital		29a. Certifier 41 Certifying Physic	ion. To the hort of									
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one)	ian: To the best of my knowledg	ge, death o nd/or inve	occurred at estigation, in	the time, n my opin	date and p ion, death	place, and occurred a	due to the cau at the time, dat	use(s) and n te and place	nanner as st , and due to	tated. the cause(s)
	o tha ithin : o tha mple	Mec	29b. Signature and title of certifier	and manner stated.			icense n					ed (Month,	
	F 3 F 8		· Com Do	tone o	DC	1	47	111	501	25	L. Date sign	The state of the s	
	^	}	30 Name and address of second	plated cause of death (the see	- C	1 1	12	$\varphi i \supset$	/		12	13	105
	2		30. Plame and address of person who com	Dieted Cause of death (Item 23a)	GINDE, P	, JE	A.	MOC	to	2	201	Iln.	PM
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	LW	CIV	1	16.3	37	1 40	UW!		1 (022
	Registra	-	DEC - 6 200	Diagram It	1	20021							21000

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SUTH /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 KF Yrs **Director** 220 34 4351 Oct 1, 1909 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State r items 23e or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☐No Howard Dayton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Linthicum Road death v 21036 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. 3m 27 ie marked other then "netural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🔀 No other traumatic event, the Medical Erar ģ Specify: 3 Widowed 4 □ Divorced Specify. White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Bickford Edith Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 ortment of Health a crtant: If item 27 is injury or other tra Charles C. Osborn/Son 565 West Montecito Sierra Madre, CA 91024 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cem. 12-2-2005 Adelphi, MD * 4 ☐ Donation 5 ☐ Other (Specify) permit.
Deportra
Imports
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 chan 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TNEUMONIA /Medical Due to (or as a consequence of): Examiner Lowcolou Sequentially list conditions, if any, leading to immediate cause. Enter linearing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed as the burial-transit attending physician and Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death Month Year 1 ⊔ Yes 2 100 9 □ Unknown 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 DUnknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No has autopsy Division of Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes Inpatient this 2 ER/Outpatient 3 DOA 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 Natural 5 Pendina death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Chack only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 31172 QDleted cause of death (Item 23a) (Type, Print) COUMBIA MD 10700 CHANTER 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Ma	aryland / Dep	artment of	Health and	•			1442
					Ce	rtificate of	Death		Reg. No.	00 46	1446
	Physici	-	Decedent's Name (First, Middle, La	•				2. Date of D			. Time of Death
	/Medi		James Irvin O	range, Sr.					29. 20	O5 Year	2:00P M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Dea			ounty of Death	2.001
			Civista Medical	Center		I a l	Plata			1 7	
	Funeral		5. Social Security Number 6. 5	Sex 7. Age	(In yrs. last birthday,	If Under 1 Year	r If Under 24 Hi		irth	harles 9. Birthplace	(State or Foreign
	Director		229-12-0412	1 ∑ M 2□F	91 _{Yrs.}	Months Days	Hours Mi	May	22 191	4 Virgi	_
9	D .		Usual Residence of Decedent					1 2			
	how	١.	10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City Limits
	Ma -i-s	횼	Maryland Charle	es	Charlot	te Hall					1 ☐ Yes 💥 No
	h th	i.e	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Country?	
	h wit	Funeral Director	12999 Hallovan	T.ano		20	0622		IIn	ited Stat	-OC
	deat ms	Jer	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of If Yes, specify Cut		Specify Yes or No		Race - American Ir	
0	after or Ite	臣	1 Never Married 2 Married	Armed Forces? 1 ∑Yes 2 □ N If Yes, Give	00 0 10	V		rto Rican, etc.)		Black, White, etc.	
3	ours a	Þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	6-9-45	1 ☐ Yes 2 ☐ No	Specify:		Sp	_{ecify:} white	2
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-1 show ont, the Medical Exactinar must be redified at	Completed	15. Decedent's Ed			dent's Usual Occu	pation		16b. Kind	of Business/Industr	v
2	hin .	pg.	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire	a during most of w ad)	orking			,
7	d wit	DO.	12	0010g0 (1 401 5	" Le	ead Mecha	anic		Air	line Comp	any
Ş	il Hygi other /ent, I	Bec	17. Father's Name (First, Middle, Last,				18. Mother's Na	ame (First, Middle	, Maiden Su	mame)	
Maryland	denta fenta rked	ToE	John Albert Oi	range			Mary	Eliza Cl	lay Ora	ange	
3	2 should be filed within 72 hours after death with the Maryian and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Existin in primar be notified as	_	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	t and Number or F	Rural Route Numb	er. City or To	own, State, Zip Coo	(a)
	and 2 salth a n 27 is		James I. Orano	æ Jr.	364			\missvil]			106
စ်	- I = =		20a. Method of Disposition	,0 01.	20b. Place of Dispo	sition (Name of		Date		ion - City or Town,	
2	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐		Rest Have	matory or other pla	· 1	-3-05		rstown Ma	
Baltimore,	artme ortan injur	. 4	 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 		1		-		_		-
g	permit. Pages Department of Important: If it any injury or o		21. Signature on unional Service Cicel	1	_ •	z. Name and Addre	ess of Pacility Do	ouglas A.	Fier	y Funeral	Home
			220 Parts Fater the disease of	7 30	My.	331 Easte	ern Blvd.	N. Hage	erstown	n Marylan	<u>d 21742</u>
		(23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	e.	er the mode of dy	ing, such as cardia	ac or respiratory a	rrest,	Inte	roximate rval Between
	Physician		Immediate Cause (Final disease or condition	a Seg	7505					Ons	et and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	LXUITITIE		Sequentially list conditions.	b							
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
	ecute and trans	cam	that initiated events resulting in death) Last	c							
/60,	ate be executed nysician and he burial-transit		rooding in dodn't gast	Due to (or as a	consequence of):						
200	ate b hysic the b	licai	•	d							
200	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:								
X D	tend tend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnanc	v		23d.	Date of delivery	
	e death he atten ed for u	Sici	1 ☐ Yes 2 ☐ No	4□Pregnant at t		Other (specify)			1	Month Day	Year
5	at the by the	h	9 🔲 Unknown						_		
'n	requires that the de een signed by the a hould be detached f	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco use o	contribute to the cau	use of death?
Records	w requir been si should							10	Yes 2□N	o 3 Probably	4. Unknown
ပ္သ	aw respectively	ompieted						24a. Was	an 24	tb. Were autopsy fi	ndings available
	The law ate has b page 2 st	E O						autop		prior to complete death?	
		0	25. Was case referred to medical						2.2 No	1 Yes 2	No
>		O	examiner?	Hospital:		t all Doa Ott		ath (Check only o			
	Phys ratidi	-	27. Manner of Death	28a. Date of Injury		I SEL DOA	4 Nursing i	Home 5 Resid			
5	ding F h. After funera	ţ	1. Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wor	rk?	28d. Describe h	iow injury oc	curred	
VISION	r Attending er death. rector: Atter by the funer	ca	2 Accident investigation 3 Suicide 6 Could not be		A hama (Yes 2 □ No	00/1			
$\frac{2}{5}$	or A after Dire	ertification:	4 Homicide determined	building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		City or Tox	otreet and Nu vn. State)	imber or Rural Rou	te Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	29a. Certifier ★ Certifying Ph	unining To the book of							
	Hos 24 hc Fun fely	edical	(Check only one)	ysician: To the best of niner: On the basis of and manner state	examination and/or inv	occurred at the tire of the control	me, date and place pinion, death occ	e, and due to the ourred at the time,	cause(s) and date and plac	manner as stated.	ause(s)
	the the	Mec	29b. Signature and title of certifier	and manner state	9d.						
	F 3 F 8		290. Signature and the of certifier		grun	29c. Licens			1	ned (Month, Day,	Year)
			124			D-00	53219		11/29	12005	
51	-/21/		30. Name and address of person who o		ath (Item 23a) (Type, I	Print)					
//	-/3t/		ZAFAR A. ANSARI, M		T OFC RD.	WALDORF	,MD. 206	02			
	Star Registra		31. Date filed (Month, Day, Year)	32. Redistrar	's Signature	ocathe.					
	THE STATE OF THE S	11	HEU U A A	-UUU PROF.	cond blo both	State of the state					

			For State Registrar	State of	Maryland / Depa <i>Ce</i>	artment of H			ene 2.005	40443
	Physic		Decedent's Name (First, Middle		therine Patton			2. Date of Death Month		3. Time of Death 6:09 P. M
	/Medi Examir		4a. Facility Name (If not institution		per)	4b. City, Town, or	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 217-05-5093		Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9 Bir	thplace (State or Foreign ountry) Maryland
	the Maryland r 28e-f show	rector	Usual Residence of Decedent 10a. State 10b. County Maryland 4 10e. Street and Number	Allegany	10c. City, Town or Lo		onaconing	10	g. Citizen of What C	10d. Inside City Limits 1
92	within 72 hours after death with the Maryland ene. then "neturel; or Items 23e or 28e-f show he Mcdical Exam her must be politied at	Funeral Director	11. Marital Status 1 Never Married 2 Marr	12. Was Deceder Armed Forcined 1 Yes, Give	XNo	Was Decedent of His If Yes, specify Cubar	21539 spanic Origin? (Sp n, Mexican, Puerto Specify:		14. Race - Ame Black, Whit	S.A.
Maryland 21215-0036	be filed within 72 hours after death with the Marylan nat Hygiene. ad other then "neturel", or flems 23a or 28e-f show event, the Medical Examinations! be indiffied at	Completed by	3 Widowed 4 Divorced 15. Decedent (Specify only highest Elementary/Secondary (0-12)	Year or Date	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of work	ing 10	Specify: 6b. Kind of Business	White //Industry
yland 2	be filed htal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Tho	Last) mas Edward M			18. Mother's Name		aiden Sumame) rginia Preston	
	1 and Health Bm 27 ther t		20a. Method of Disposition	am Patton-son	159 20b. Place of Dispo	19 Lower Geo	orges Creek	Rd. S.W.Lor	City or Town, State, Inaconing, Mar	yland, 21539
Baltimore,	permit. Pages Department of Importent: If it any Injury or o		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S _t) 21. Signature of Funeral Service (pecify)	Frostbur	natory or other place g Memorial F	ark	December 03, 2005	Frostburg, P.A., 8 East M	Maryland
	MILL SEC	N /	23a. Part1. Enter the disease, or shopk or heart failure. List	only one cause on each	sed the death. Do not ento h line.	er the mode of dying	Lonacor , such as cardiac o	ning, Maryla	nd. 21539	Approximate Interval Between Onset and Death
ı	Physician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or	as a consequence of):	accida	<i>†</i>			3 days
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. This index ying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of): as a consequence of):					
P.O. Box 6	death certiti e attending d for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli	ivery Day Year
	The law requires that the ate has been signed by the page 2 should be detache	by		2.4.	h but not resulting in the un	derlying cause giver	in Part I.		cco use contribute to	the cause of death?
tal Rec		Be Completed	Demartia 25. Was case referred to medical				OG Plant of Double		d? prior to death?	topsy findings available completion of cause of
Division of Vital Records,	ding P h. Atter t tunera	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident investig. 3 Suicide 6 Could n	ation of be		3 DOA Other 28c. Injury a Work? M 1 Ye	4 Vursing Horat at 2 By 2 No	28d. Describe how	ee 6 □Other (Specinjury occurred	
Ο̈́	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical Certi	4 Homicide determing determine deter	building,	etc. (Specify) st of my knowledge, death of examination and/or inv	occurred at the time	date and place	City or Town, S	State)	stated
	To the vithin 24 To the Complete	2	29b. Signature and title of ceptifier	and The	lin 40	29c. License 1		29d.	Date signed (Month	, Day, Year)
	Sta	te	30. Name and address of person was Dec	IN MD	f death (Item 23a) (Type, F 26 Douglus strar's Signature	/1	Lonne	MINS N	Dec. 2, a	21537
	Registra	त्रा	6 E- W	0 2000	Carlos III I	2030 6				

•••		CA-A-	artment of Health and Me	Reg.	211115 1.01.1.1.
Physici /Medic Examir	cal	Albert Arthur Pete 4a. Facility Name (If not institution, give street and number) 5318 Bucktown Road		2. Date of Death Month November	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220–10–6383 Usual Residence of Decedent	Months Days Hours Min.	B. Date of Birth (Month, Day, Ye Sept. 7,	
th the Marylan or 28e-f ehow	Director	10a. State 10b. County 10c. City, Town or L MD Dorchester 10e. Street and Number	Cambridge 101. Zip Code	10g.	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f ehow other treumetic event, the Maralcal Examination at the notified at	Funeral	1 Never Married 2 Married 1 124 Yes 2 No	21613 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	USA 14. Race - American Indian, Black, White, etc.
within 72 hours ene. then "neturel"	Completed by	15. Decedent's Education (Specify only highest grade completed)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) maintenance		Specify: white Kind of Business/Industry ire cloth mfg.
d 2 should be filed within 72 hours af this and Mental Hygiener 77 is marked other than "neturel; or treumatic event, the Madical Exercited.	To Be Co	17. Father's Name (First, Middle, Last) Tuffield Frank Pete	18. Mother's Name (/	First, Middle, Maid Seymour	den Sumame)
ages 1 and 2 s nt of Health an If item 27 ier or other treur		Eleanor Willey daughter 5507 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Mt. Holly Rd., Eas: osition (Name of matory or other place)	t New Mar 9 20c.	rket, MD 21631 Location - City or Town, State
permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21. Signature of Funeral Service Licensee	r Memorial Park 12, 2. Name and Address of Facility Thom 00 Locust St., Camb	mas Fune ridge, M	ral Home P.A.
Wedical Examiner American and American and India physician and India se the burial-transit	I Examiner	Shock, of fleat failure. List only one cause on each line.	Heart Discere		Approximate Interval Between Onset and Death
death certifi e attending d for use as	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
The law requires that the ste has been signed by the bage 2 should be detache	þ	Part II. Dther significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
vicien: The law certificate has I rector, page 2 s	Be Completed	25. Was case referred to medical examiner?	26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No
hye this	Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 Ft/Outpatien 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Strictle 6 Could not be	28c. Injury at Work? M 1 Tyes 2 No	Residence . Describe how inj	6 □Other (Specify) ury occurred
To the Hospitel or Attend within 24 hours after dealt To the Funerel Director: completely filled in by the	edical Certifi	4 Homicide determined 29a. Certifier (Check only 20a. Certifier (Check only 20a. C	Occurred at the time, data and place, and	due to the source	
To the k within 24 To the F complete	Medi	29b. Signature and title of certifier	29c. License number D 47924	29d. D	ate signed (Month, Day, Year)
Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, In 1970 MAN THAN 4 300 AURORA 31. Date filed (Month Day Year 0 2005 32. Registrar's Signature	CT CAMARIACI	19	0 2/6/3

		,	FOR	partment of Health and Menta ertificate of Death	Hygiene 05	40445
	Physici		1. Decedent's Name (First, Middle, Last) Dale Curtiss Price	. Mor	e of Death Day Year Nember 25 200	
F.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath
			Dorchester General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Cambridge If Under 1 Year If Under 24 Hrs. 8, Date	Dorche 9, Bi	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda of the second of the sec	Months Days Hours Min. Jan	nth, Day, Year) 1921 Ir	rthplace (State or Foreign ountry) ndiana
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
ς	e-f sho	ctor	MD Dorchester	Cambridge		1 □ Yes 2 XNo
3	th with the 23e or 28 int be no	Funeral Director	10e. Street and Number 1430 Town Point Road	10f. Zip Code 21613	10g. Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	Þ.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Sive Year or Dates: WWII	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, € □ Yes 2 M No Specify:		
Maryland 21215-0036	within 72 ho ane. than "natur	Completed	(Specify only highest grade completed) (Gilfe Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired) restorer	16b. Kind of Business	
2	t Hygie other t	Be Co	11 17. Father's Name (First, Middle, Last)	18. Mother's Name (First,		les
ylar	should be find Mental harmarked of	To B	Charles O. Price	Christine		To Codel
Mar	and 2 sh ealth and n 27 Is m			ailing Address (Street and Number or Rural Route 30 Town Point Road, Cam	· ·	613
ore,	of Hea of Hea fitem		1 1 A Burial 2 Cramation 3 Hamoval from State	sposition (Name of Date crematory or other place)	20c. Location - City o	r Town, State
altimore,	iif. Pages urtment of i ortant: If its njury or o		4 □Donation 5 □Other (Specify) Maryland 21. Signature of Funeral Service Licensee	Veterans Cem. 12/1/0	5 Hurlock, M s Funeral Home	
Ba	Depa Impo any in		Brik. Bus	700 Locust St., Cambrid		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on earn line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac or respir	atory arrest,	Approximate Interval Between Onset and Death
760,	ife be executed sysician and ne burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
687	ficafe to physical sthe b	edical	d			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med		3 Ectopic pregnancy 5 Other (specify)	23d. Date of de Month	elivery Day Year
rds, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23	e. Did tobacco use contribute to	o the cause of death?
Il Records,		Completed			a. Was an autopsy performed? Yes 2 No 1 Yes	utopsy findings available completion of cause of s
Vita	ysician: The l is certificate ha director, page	o Be	25. Was case referred to medical examiner? 1 — Yes 2 No Hospital: 1 Inheritate 2 — ER/Outpai	26. Place of Death (Check tient 3 DOA Other: 4 Nursing Home 5	k on <i>ly one)</i> ☑ Residence 6 ☑Other <i>(Sp</i> e	acify)
n of	ding Phys h. After this funeral di	on: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injur	e of 28c. Injury at 28d. De	scribe how injury occurred	
Division of	or Attendir after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		eation (Street and Number or F or Town, State)	lural Route Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do and manner stated.			
)	To the within To the compl	Me	29b. Signature and vitle of certifier Mulliam Par	29c. License number 943238	29d. Date signed (Mon	
			30. Name and address of person who completed cause of death (Item 23a) (Type 100)	Bramble St. Car	Novemb mbridge,	n 1 21413
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Bramble St. Car	,	
DH	IMH 17 Rev 1/2	,21	190 4 0 2003 Blance &	Aporta		

			1 - State State Registrer	of Maryland / Depa Cea	artment of Health and rtificate of Death	Mental Hygié		+0446
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Delores R. Routzahn			2. Date of Death Month November	Day Year 28. 2005	3. Time of Death 7:00 A M
7	Exami		4a. Facility Name (If not institution, give street and no Northampton Manor	umber)	4b. City, Town, or Location of Deat Frederick		4c. County of Death Frederic	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F Usual Residence of Decedent	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	9. Birthn Cour 1943 Mary	place (State or Foreign ntry)
	anyland show	J.	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	ath with the Marylan s 23a or 28e-f show ust be notified at	Direc	Maryland Frederick 10e. Street and Number 612 W. Patrick St. Apt.	Freder	10f. Zip Code 21701		Citizen of What Cour	
36	after de or Items	by Funeral	11. Marital Status 12. Was De Armed I	cedent Ever in U.S. 13. \ Forces? 1 2.T.No	Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puerl		14. Race - Americ Black, White,	ean Indian, etc.
21215-0036	- × 30	Completed t	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0.12) College	(f) (1-4or 5+) 16a. Deced (Give life. L	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking	o. Kind of Business/Ind	dustry
land 21	be filed stal Hygi of other	To Be Cor	12 17. Father's Name (First, Middle, Last) William L. Crouse	Nurses	18. Mother's Nar	ne (First, Middle, Maid Specht	Iome Health	icare
e, Maryland		-	19a. Informant's Name/Relationship (Type, Print) Carol Rigler/Sister	8411 I	g Address (Street and Number or Ru East Lassie Court	, Walkersv		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tree QDCS.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 1 □ Donation 5 □ Other (Specify)	State	sition (Name of natory or other place) 1 Spires Cem. 12/		: Location - City or To	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	le7 1	. Name and Address of Facility $$	tauffer Fu Pike, Fred	neral Home	2
68760,	Physician /Medical Examiner the porter the private the	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	caused the death. Do not entereach line. So reserved to the consequence of): Tabety mellor as a sonsequence of): O (or as a consequence of):		correspiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 687	death certiff e attending od for use as	by Physician/Medic	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver	ry Day Year
Records, P	The law requires that the ate has been signed by the page 2 should be detache	ted by Pt	Part II. Other significant conditions contributing to a mouth of blessity	death but not resulting in the un	derlying cause given in Part I.		co use contribute to the	e cause of death?
_	ician: The law r certificate has be rector, page 2 sh	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑	/ death?	psy findings available inpletion of cause of
	ding Phys After this funeral dii	atlon: To Be	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatient of Injury th, Day Year) 28b. Time of Injury	0.1	th (Check only one) ome 5 Residence 28d. Describe how in)
=	ital or Atters as a street de rai Directo	Certification:	4 Homelas	e of Injury - At home, farm, stre ling, etc. (Specify)		City or Town, Sta		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) and mar	e best of my knowledge, death pasis of examination and/or inve ner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	red at the time, date a	and place, and due to	the cause(s)
	7		29b. Signature and title of certifier	mD.	29c. License number		Date signed (Month, D	•
,	\ 		30. Name and address of person who completed cau Syed (W. Hague 31. Date filed (Month, Day, Year) 32. F	se of death (Item 23a) (Type, P	D005463 Vontclaire	Aue Fr	ederick r	nD 21701
	Sta Registra		DEG 0 1 2005	10	Book			

DHMH 17 Rev 1/2001

Registrar

			1 - For Si	-	artment of Health and M	lental Hygier	711115	40448
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		Delbert Thomas	s Roy		December .	Day Year 5. 2005	11:00 A ^M
	Examin		4a. Facility Name (If not institution, give street	t and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			99 Oak Street, Apt.		Mountain Lake Pa			rett
ı.	Funeral		5. Social Security Number 6. Sex 1 ☑ M	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	ar) 9. Bir	thplace (State or Foreign ountry)
	Director		214-36-7134 Usual Residence of Decedent	68 Yrs.		Sept. 18,	193/ We	st Virginia
	/land		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Man,	to	MD Garret	:t	Mountain Lake	Park		1 ∰ Yes 2 □ No
	h the	Funeral Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Co	ountry?
	th wit	aD	99 Oak Street, Apt.	4-B	21550		USA	
	r dea	ner	11. Marital Status 12. V		Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 Never Married 2 Married	☐Yes 2☑No Yes Give	1 ☐ Yes 2 ☑ No Specify:	,	Specify: Wh:	
Ö	hours tural'	d b		ear or Dates:	death Havel Occupation	401		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show the Mcdical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade con	npleted) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 165.	. Kind of Business	rindustry
72	iene.	om	Elementary/Secondary (0-12) (College (1-4or 5+)	Coal Miner		Coal Mir	iino
ğ	filled I Hyg other	Be C	17. Father's Name (First, Middle, Last)			First, Middle, Maid		IIIIg
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or othar treumetic event, the Medical Examinar must be multiled at once.	To E	Edison Riley	Roy	Haze1	Alice	Mark1	ey
an	2 sho and I is me eume	9.	19a. Informant's Name/Relationship (Type, I	Print) 19b. Mailin	ng Address (Street and Number or Rura	al Route Number, City	y or Town, State, .	Zip Code)
2	and ealth m 27	1.5	Cindy M. Wilburn/dau		Castle Ridge #32,	The state of the s		
Baltimore,	ges 1 it of F if Ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	val from State	sition (Name of natory or other place)	Date 20c.	Location - City or	Town, State
Ħ.	t. Pa rtmen rtent: rjury	1	'4 □Donation 5 □ Other (Specify)	Ashby Ce	THE TAXABLE PARTY OF THE PARTY		akland, 1	
Bal	permi Depa Impo any ir		21. Signature of Funeral Service Licensee		2. Name and Address of Facility		S. Second	
			23a. Part1. Enter the disease, or complication		er the mode of dving, such as cardiac of		land, Md	Approximate
И	Williams		shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.	-,			Interval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death)	Ischemic Cardiomy Due to (or as a consequence of):	opathy			vears
	Examiner			Due to (or as a consequence or).				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	ocutec nd transi	Examiner	Cause (Disease or injury that initiated events c					
8760,	ate be executed hysician and the burial-transit	Ě	resulting in death) Last	Due to (or as a consequence of):				
87	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d					
9 X	certif iding ise as	/Me	IF FEMALE: 23c. I	yes, outcome of pregnancy			23d. Date of del	ivos
Box	atter for L	clar	in the past 12 months?	Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Month	Day Year
<u>Р</u> О	that the death certific ed by the attending p detached for use as	hys	9 Unknown	Unknown				
	w requires that been signed t should be det	by P	Part II. Dther significent conditions contribu	ting to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
ğ	aquire en siç ould b			-		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
ecc	has be	Completed				24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
<u> </u>	10	Con				performed? 1 ☐ Yes 2 X	/ death?	
/ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			(Check only one)		
of	Physi this o	2	1 Yes 2 No Hospi	1 Inpatient 2 EN/Outpatien				cify)
Division of Vital Records,	Attending Physicien: or death. ector: After this certifics by the funeral director, I	tlon		Ba. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
S	l or Attencafter death Director:	fica	3 ☐ Suicide 6 ☐ Could not be 2	Be. Place of Injury - At home, farm, stre		28f. Location (Street	and Number or Ru	ural Route Number.
2	after f Direction by	Certification;	4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta		
	Hospitel		29a. Certifier (Check only 2 Medical Exeminer:	n: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner as	stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ledical	one)	On the basis of examination and/or invalid manner stated.	vestigation, in my opinion, death occurr			
	To To Con	Σ	29b. Signature and title of certifier	00	29c. License number	29d. D	Date signed (Monti	h, Day, Year)
•		,	Van Dur	1 xxed	H26154		12/6/20	05
	5		30. Name and address of person who comple					
	Sta	te.	Paul Daniel Miller 31. Date filed (Month, Day, Year)	D.O. 69 Wolf Ac 32. Registrar's Signature	res Drive, Oaklan	d, Md. 215	50	
***	Registr		DEC - 6 2005		Control			
	*			- January January	- garan			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Yeer **Physician** Joan Ritenour November 29 2005 11:53 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City 8494 Roberts Road Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛱 F 2/25/1931 74 Maryland Director 212 30 6279 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Ellicott City Howard 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 8494 Roberts Road 21043 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 █XNo Specify: White Specify: ģ 3√2 Widowed 4 □ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 10 Homemaker Own Home other or other traumatic event, permil. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 90cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Davidson Rossia Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Smith/Daughter 8494 Roberts Road Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Crestlawn Mem. Gards. 12/2/2005 Marriottsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pk. Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Mounto /Medical Due to (or as a consequence of) **Examiner** cleroi 18110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Tyes 24 No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes SE No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 € No 1 🗌 Inpatient 2 ER/Outpalient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after on Funeral Direct filled in by 4 🗌 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title if certified 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Barnie MD MD 115 obcit Mwine-008/26 31. Date filed (Month, Day, Year) State 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State Registrar	State of Ma	*	ertificate of I			eg. No.	5 40450
Physici		1. Decedent's Name (First, Middle, Last Martha Beth Komin		s			2. Date of Deat Month 11/22/2	Day Y	'ear 2:27 P
/Medic Examin		4a. Facility Name (If not institution, give Laurel Regional F	street and number)		4b. City, Town, or Laurel	Location of Death		4c. County of	12121
Funeral Director		5. Social Security Number 6. Se 254-38-5188	x 7. Age	(In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/24/	Year)	B. Birthplace (State or Fore Country) eorgia
aryland ahow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I					10d. Inside City Lim
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Hygiene. Other than "n	Completed	(Specify only highest grad	College (1-4or 5- 2	+) life.	Maker			Own Hom	
and Mental Hy	To Be (17. Father's Name (First, Middle, Last) Lenton F. Kirklan	ıd			18. Mother's Nam Annette	e (First, Middle, M Cromart:		
h ar 7 la trau		19a. Informant's Name/Relationship (T) Stanley J. Kominic			ling Address (Street a				
points. Tages lands. Department of Heelth Important: It Itam 27 I any Injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		position (Name of ematory or other place	e)	Date	20c. Location - Ci	ty or Town, State
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this certificral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ≱Inpatien	nt 2□ER/Outpatio	ent 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		e) ence 6 □Other	(Specify)
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within 24 hours el To the Funeral D completely filled i	edicai	29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exami	rsician: To the best of iner: On the basis of and manner stat	examination and/or i	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
within 2 To the	Me	29b. Signature and title of certifier	١.		29c. License				Month, Day, Year)
		30. Name and ad ress of person who ca Eugenio Machado.						11/23/20 904	05
Sta	ate	31. Date filed (Month, Day, Year)	32. Registra		NUAU SIIV	er obiru	5, I'II 20'	7 04	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend items 23a pt II, 25 per me 8834 4-12-06 vt

State of Maryland / Department of Health and Mental Hygiene
Amend items 23a,c per me 8834 4-12-06 vt

Reg. No. For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Jerry Lynn Repp DM 2.00 2000 30 Nov /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Western Maryland Hospital Center Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 10, 1959 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** X□M 2□F 216-76-2331 46 Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Exercine must be notified at MD Washington Clear Spring 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13628 Blairs Valley Rd. 21722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: Completed by 3 ☐ Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) masonry company Elementary/Secondary (0-12) College (1-4or 5+) brick layer 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joe Frederick Repp Ellen Agnes Mongan if of Health and Menfa 136.28 Blairs Valley Rd. Clear Spring, 19a. Informant's Name/Relationship (Type, Print) Ellen A. Repp mother 20b. Place of Disposition (Name of Dec. 3, 2005 Blairs Valley Cemetery 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring, MD permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur unerat Serv ight te 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line.

Image: P.O. BOX 310 Clear Spring, MD 21722

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46561 30 MO 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 1500 Pennsylvania Avenue

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

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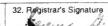
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Division of Vital Records, P.O.

State Registrar 31. Date filed (Month, Day, Year) DEC 0 2 2005

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Hagerstown, MD 21742

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Pages 1 and 2 should

Baltimore,

Box 68760,

physician

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death ms 2	Funeral Director	11 Marital Status 12. Was	Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ	
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2 sho and is m		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number or Ru			-
DESIGNATION OF BY INTERVIEUR ALLES-DUCOO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or othar traumatic event, the Medical Evarther must be notified at		E. Sue Reall/wife		79 King Wildesen R			
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10+1A		30. Name and address of person who completed Charles A. Walsh M.D		th St., Oakland, M		12/5/2005	

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8	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he M. dical Examinal in ust be notified at	Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced Year or Da	tes:	1□ Yes 2	X1 NO	Specify:			Spec	eify: W	nite	
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	1 and 3 Health tem 27 I		William P. Short, Jr	. (son) 10	2 Par	ole C	irc1		Elktor	MD.	219	21	
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ä	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Mannes.		21. Significant Program Service License	G^2	2. Name and	Address	of Facility	1 н	ome of	Stan	hon	T. Sa	haod
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Me	29b. Signature and title of certifier		29c.	License n	number		29	d. Date signe	ed (Month	Day, Year)	
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	Le		30 Name and address of person who completed cause	of death (Item 23c) (Time		1071	7		1	ECTMBE	n 1, 1	T0132	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** DECEMBER 7 2005 LELIA MINERVA STELZER 10:16 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PLATA, MARYLAND CIVISTA MEDICAL CENTER CHARLES 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Days Hours 1 M 20 76 218-24-6301 SEPT.6,1929 MARYLAND Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow other treumetic event, the Medical Examiner must be notified at 1 Yes No Funeral Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a death v 5430 WASHINGTON AVENUE 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: WHITE If Yes, Give Year or Dates: 1 ☐ Yes 2XXXIo Completed by 3 ♥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 ENGINEER & P TELEPHONE CO. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental LYON SATTERLEE GARNER LELIA BLANCHE POSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar Important: if Item 27 is eny Injury or other treught. GWYNETTE PIPER-SISTER 5430 WASHINGTON AVE., LA PLATA. MD 20646 ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) REST CEMETERY 12-12-05 LA PLATA, MD MT. 21. Signature of Funeral Service Licensee M00478 22) Name and Address of Facility KAYMOND FUNERAL SERVICE, P.A. With 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNKNOWA Metastatu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other/significant conditions centributing to death but not resulting in the underlying cause given in Part I. COI d 1 Yes 2 No 3 Probably 4 Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No autopsy page 2 No 1 Yes or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. tnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Tyes 2 No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide o the Hospital Vaccrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Della D-0026262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel J. Kleiman, MD 11711 Livingston Road, ICCU Dept. Fort Washington, MD 20744

31. Date filed (Month, Day, Year)

SEC 1 4 2005

32. Edgistrar's Signature State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		1 Onhe	wo						Nov	ember 27	7, 2005
		30. Name and address of person	who completed cause of d	eath (Item 23a)	-		-				

State Registrar

J. A Row Locke (Manth, Day, Year) 32. Registrar's Signature

		1 State	Department of Health and M Certificate of Death	1	11115 1.01.56
Physi	i cian	Decedent's Name (First, Middle, Last)	wetnam		3. Time of Death
/Med Exam	dical	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospi	4h City Town on Location of Dooth	11 2	5 2005 T.99 PM 4c. County of Death Montgo mery
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birt		8. Date of Birth (Month, Day, Yea Jan. 30,	9. Birthplace (State or Foreign Country) Washington, DC
death with the Maryland me 23a or 28a-f ehow	tor	10a. State 10b. County 10c. City, Town Maryland Prince George's Adely			10d. Inside City Limits 1 ☐ Yes 2 💆 No
with the	i Directo	10e. Street and Number 1926 Saratoga Drive	10f. Zip Code 20783		Citizen of What Country? USA
after or ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marned 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No II Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	crfy Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify. White
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DIV oitel or A urs after oral Direction by	Certif	4 Homicide building, etc. (Specify)		City or Town, Sta	ate)
DIVISIO To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated.	the state of the s		
To To	×	296. Signature and title of certifier Sean S Saedi,	WD 0-60322	298. L	11/26/2005
12		30. Name and address of person who completed cause of death (Item 23a) (Sean S Saedi/MD - 11120 New Han	pshire Ave, Suite 309	5, SilverSi	oring, MD, 20904
S Regi	State strar	29b. Signature and title of certifier 30. Name and addr ss of person who completed cause of death (Item 23a) (Sean S Saed), MD 11120 New Harr 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Agosta		

			1 - For State Registrar	e of Maryla	-		t of Health of Deat			giene	05	4045	7
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Dea Month	Day	Year	3. Time of E	
	/Medic		Jacqueline McIntyre S			4. 65			Novembe	-	2005 unty of Deat	12:45	M
	Examin	er	4a. Facility Name (If not institution, give street ar Montgomery General Ho			_	Town, or Locatio ney	n or Death			ntgome		
27	Funeral	100	5. Social Security Number 6. Sex		s. last birthday)	If Under	1 Year If Und	er 24 Hrs.	8. Date of Birth	1		hplace (State or ountry)	Foreign
	Director		578-34-7133 1□ M 25€	^{] F} 76	Yrs.	Months	Days Hours	s Min.	(Month, Day	1928	Was	shingtor	
	pu ≱∷		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation						10d. Inside City	/ Limits
	Maryli f sho	ō	Maryland Montgomery		lver Sp							1 □ Yes	
	7.28a-	Directo	10e. Street and Number			10f. Zip	Code			10g. Citizer	of What Co	untry?	
	death with the Maryland ms 23a or 28a-f show Frival by rollited at		14619 Edelmar Drive			20	906			US	SA		
_	be filed within 72 hours after death with Hygiest and other then "naturel", or items 23a event, ins Maxical Exeminating and	y Funerai	1 Never Married 2 Married 1 If Ye	Decedent Ever in ed Forces? Yes 2 □XNo		Was Deced If Yes, spec	ent of Hispanic Cify Cuban, Mexic		cify Yes or No- Rican, etc.)		Race - Ame Black, White Becify: Wh:		
15-003b	hours ture!	ed by	3 ☐ Widowed 4 ☐ Divorced Yea 15. Decedent's Education	r or Dates:	16a Dece	dent's Usua	I Occupation				of Business/		
Ò	iin 72 n "na	Completed	(Specify only highest grade compl		(Give	kind of wor DO NOT us	k done durina m	ost of workii	ng			y County	7
7	d within glene.	mo	Elementary/Secondary (0-12) Colle 12	ege (1-4or 5+)	S	ecret	ary			Scho	ols		
_	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mannatic event, the Mannatic event, the Mannatic event.	Bec	17. Father's Name (First, Middle, Last)						(First, Middle,	Maiden Su	mame)		
Z Z	ould by Ment	To	William McIntyre					Nita M				-	
Z	of 2 sh th and th and traum traum		19a. Informant's Name/Relationship (Type, Prin Robert D. Schafer/ Hu		1.73	-	(Street and Num mar Driv						
ore,	permit. Pages 1 end 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic ex once. c		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal	20b.	. Place of Dispo cemetery, crer	osition (Nan	ne of ther place)	Novemb		20c. Locat	ion - City or	Town, State	
baitimore	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	Me Me	etropolit	an Cre	natory	200		lexand	ria, Vi	rginia	
g	permit. I Departm Importal eny inju		21. Signature of Funeral Service Licensee				Address of Fac Collins						
- 4	HOE & G		23a. Pert1. Enter the disease, or complications	that caused the de			ersity Bly				MD 209	O1 Approximate	
	Physician /Medical Examiner		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		rotic Ci		, -					Interval Betw Onset and Do	een
	ate be executed hysicien end the buriat-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a conse									
O. BOX	he death certific the attending p thed for use es	Physician/Me	in the past 12 months?	s, outcome of preg Live birth 2 Fe Pregnant at time of Unknown	ntal death 3	Ectopic pro				23d	. Date of deli Month		e a r
cords, P.	law requires that the de as been signed by the a 2 should be detached fo	by	Part II. Dther significant conditions contributing CHRONIC RENAL		-	nderlying ca	ause given in Pai	rt 1.		bacco use		the cause of de	
r	The law requir ate has been s page 2 should	Completed	9						24a. Was a autop: perfor	an 2 sy med? 2 1 No	4b. Were au prior to death?	topsy findings as completion of car	vailable use of
	Physicien: The libility of the late of the	Bec	25. Was case referred to medical examiner?					ace of Death	(Check only or	/V			
5	Physic this co al dire	2	1 No Hospital:		ER/Outpatier				ne 5 Resid			cify)	
	After After funer	ation:	1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes 2		28d. Describe h	ow injury or	ccurred		
	al or Attending s after death. I Director: After d in by the fune	Certifical		Place of Injury - At building, etc. (Spec	home, farm, str cify)			2	28f. Location (S City or Tow		umber or Ru	ral Route Numb	er,
	To the Hospital or Attending Phys within 24 hours attendeath. To the Funarel Director: After this completely filled in by the funeral di	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and	Al - L - in - f	antina and/ar in		the many contractors of			lake end of		A - AL / - 1	
	To th within To th comp	Me	29b. Signature and title of certifier			290	. License numbe	ər	- 2	29d. Date si	igned (Monti	n. Day, Year)	
•	10		Hohily &	mo		E	0030	414	/	Yoven	BER	28,20	105
	, ,		30. Name and address of person who completed	cause of death (It	ет 23a) (Туре,	Print)	- 0			11		,	
Tox	90 Wh. 00	. 0	31. Date filed (Month Pay Year)	32. He bistrar's Sig	1 RINCA	2 PH16	IP UR	, 01.	NEY, I	MARY	LAND		
	Sta Registr		29b. Signature and title of certifier 30. Name and address of person who completed TOWN HERRING M. 31. Date filed (Month, Pay Year) 0 2005	Miner	Ji A	soci	P						

		1 - State Ragistrar WCHD/SH 12/ 1. Decedent's Name (First, Middle, Last		Ce.	rtificate	e of L	Jeath	2	. Date of Death		UJ	3. Time of Death
hysici		Robert William S	chissler					,	Month Decembe:	Day	Year 2005	4:00 A. M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of De				nty of Death	
- Admini	6.	Avalon Manor Healt	h Care Cente	r		Hage	erstown				Wash	ington
ineral		5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under 24 H	irs. 8	. Date of Birth (Month, Dey,	Year)		plece (State or Foreiguntry)
ector		315-24-1235	^{2M 2□ F} 76	Yrs.	Wichtins	Days	Tiodis iv	I	Feb. 2,1	929	Ind	iana
<u>_</u> (I		Usual Residence of Decedent 10a. State 10b. County	10c. C	city, Town or Lo	ocation							10d. Inside City Limits
event, the Medical Exempler must be nothing at	ō	Md. Washing	rton	Hagers	stown							1 ☐ Yes 2 XNo
	Funeral Director	10e. Street and Number	,		10f. Zip	Code			10	g. Citizen	of What Co	untry?
	D E	11403-A Stonecroft	Ct.			217	42				U.S.	A
	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	dent of His	spanic Origin? n, Mexican, Pu	(Specification (Speci	fy Yes or No-		Race - Amer	rican Indian,
	F	1 Never Married 2 Married	1 ☐¥es 2 ☐ No If Yes, Give 50 Year or Dates:		1 ☐ Yes		Specify:				cify:	White
	d by	3 ☐ Widowed 4 ☐ Divorced			1 11 11							
	lete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usua kind of wor DO NOT us	rk done d	luring most of i	working	'	bb. Kina o	f Business/l	naustry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2		DO NOT us Ma	inagé	r			M	otel	
		17. Father's Name (First, Middle, Last)					18. Mother's	Vame (F	First, Middle, M	aiden Sum	ame)	
	To Be	William Conrad S	chissler				Luci	nda	Miller			
		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address	(Street a	and Number or	Rural P	Route Number,	City or Tov	wn, State, Z	ip Code)
		Mabel L. Schissle	r (Wife)	11403	-A St	onec	roft C		Magersto	wn, M	d. 21	742
5	1 3	20a. Method of Disposition 1 Burial 2 Commation 3 D		Place of Dispo cemetery, crei	matory`or o	ther place	Dec	Date 3	_	Dc. Locatio	n - City or 1	Town, State
i		4 □ Donation 5 □ Other (Specify,		ithsbur	g Cre	mato		005		Smi	thsbu	rg,Md.
any njury or other traumatic	į i	21. Signature of Funeral Service Licens	99				s of Facility		125	25 B	radbu	ry Ave.
5 O		John Ja	DAVIS MO								urg, Mo	1. 21783
an	77 (23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	ath. Do not en	viva J	e or crying	00	viac or r	1	CLON	7	Approximate Interval Between Onset and Death
lical		resulting in death)	Due to (or as a conse	equence of):	1464	free free	. 1	-	0	e Lind		COX
ner		Sequentially list conditions,	covages t	oug 1	FINY	IE	alli	re			_	104
-	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a a conse	equence of):							- 1	100
	хап	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):								11 /
	cal E			,								
			d									
	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		-					23d.	Date of deliv	/ery
	clai	in the past 12 months?	1 □ Live birth 2 □ Fe 4 □ Pregnant at time ot		□Ectopic pr □ Other (sp						Month	Day Year
	hysi	9 Unknown	9□ Unknown						Y			
	by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying c	ause give	n in Part I.		23e. Did toba	cco use co	ontribute to	the cause of death?
								_	1 ☐ Yes	2 🗆 No	3 □ Pro	bably 40Unknown
	Completed							_	24a. Was an autopsy	24		opsy findings available
	E O								performe	od? No	death? 1 ☐ Yes	2□ No
	Be	25. Was case referred to medical examiner?						Death (C	Check only one,)		
	70	1 ☐ Yes 2 No		☐ ER/Outpatier			4 Vivursin	-	5 🗆 Residen			ify)
		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury Work		280	d. Describe how	injury occ	curred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М		res 2□No	0.04	Landing (Char			and Clause Marchan
•	ıı	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, sti cify)	reet, factory	, office		281	City or Town,		mber or Hui	ral Route Number,
			sician: To the best of my ke									
	Medical	(Check only 2 Medical Exam one)	nar: On the basis of examinand manner stated.	nation and/or in	ivestigation,	, in my op	inion, death o	ccurred	at the time, dat	e and plac	e, and due	to the cause(s)
		con Cincolum and title of confiler			290	. License	number		290	d. Date sig	ned (Month	, Day, Year)
	Σ	29b. Signature and title of certifier				07			1	100		
completel	2	29b. Signature and title of certifier				PJ	2323			12/	215	
completely filled in by the funeral director, page	M	30. Name and address of person who c	ompleted cause of death (Ito		Print)						215	

State of Maryland / Department of Health and Mental Hygiene

40459 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Florence Waldine Shaird December 1, 2005 01:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Beverly Healthcare of Hagerstown Washington Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Hours Vrs 83 May 17, 1922 North Carolina 244-22-3280 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "netural", or items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ᡬNo Director Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 18513 Manassas Dr. U.S.A. 21740 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 2 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor I.R.S. Pages 1 and 2 should be filed went of Health and Mental Hygie int: If Item 27 Is marked other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Knox Mary L. Eccles 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other tree 18513 Manassas Dr. Hagerstown Maryland 21740 Carolyn Anderson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/6/2005 Flinstone Maryland MSVC Rocky Gap 22. Name and Address of Facility 21. Signature of Funeral Service Lice Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner attending physician end for use es the buriel-transit or Attending Physicien: The law requires that the death certificete be executed Exami Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Last signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has the director, page 2 s 1□Yes 🕍 No 2 X No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation after death. Director: A 1 Yes 2 🗆 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š 4 Homicide 24 hours a Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) SH-0+1 368 legistrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 05

			101	partment of Health and Mental le	Hygiene	<i>C</i> O
	- · · ·		Decedent's Name (First, Middle, Last)	2. Date of Month	f Death 3. Time 6	of Death
	Physici /Medic		Carl Bainard Spessard, Jr.		ember 1 2005 7:00) AM ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Francis		19772 Meadowbrook Rd 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hagerstown If Under 1 Year If Under 24 Hrs. 8, Date of	Washington Co	
	Funeral Director		217-32-5256 1DXM 2 F 68 Yrs.	Months Days Hours Min. (Month	f Birth b, Day, Year) 9. Birthplace (State Country) Marylar	
	pu ,		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or I			
	with the Maryland a or 28a-f show be notified at	or			10d. Inside 0	s 2 No
	the N	rect	Maryland Washington Ha	agerstown 10f. Zip Code	10g. Citizen of What Country?	
	h with 23a or st be	Funeral Director	19772 Meadowbrook Rd.	21742	Inited States	
	ems 23	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.	
2	s afte	by Fu	1 Never Married 2 X Married 1 X Yes 2 No 1-5-55	1 ☐ Yes 2 XNo Specify:	Specify: White	
3	n 72 hours after death with the Manylan "natural", or items 23a or 28a-1 show solical Examiner must be notified at		15. Decedent's Education 16a, Dec	edent's Usual Occupation	16b. Kind of Business/Industry	
פ	withIn 7; iene. than "n: ire wed	Completed	(Specify only highest grade completed) (Giv life.	e kind of work done during most of working DO NOT use retired)		
7	D D Z	Соп	12 Pr	resident	Electric Company	7
	D # 0 .	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic		
	2 should be and Menta la marked aumatic ev	To	Carl B. Spessard Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route No.	Cambridge Spessard	
Z	nd 2 salth ar alth ar 27 la			772 Meadowbrook Rd. Hag		742
e G	es 1 a of Hes of Hes f item r othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, creations, continuous continuous cemetery, creations, continuous cemetery, creations, continuous cemetery, creations, continuous cemetery, creations, continuous cemetery, creations, continuous cemetery, creations, continuous cemetery, creations, continuous cemetery, creations, continuous cemeters, continuous cemete	position (Name of Date place)	20c. Location - City or Town, State	
altimo	Pag ent ent: tr: ty o		'4 Donation 5 Other (Specify) Rest Hav	ven Cemetery 12-5-05	Hagerstown Maryl	and.
	permit. I Departm Importar any injur		1	22. Name and Address of Facility Douglas	A. Fiery Funeral H	Iome
	40340		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	331 Eastern Blvd. N. Ha		
h.			shock, or heart lafture. List only one cause on each line.		Interval Be	tween
	Physician /Medical		disease or condition resulting in death)	CARDIOMYOPA	+1177 YEAR	<u> </u>
	Examiner		ATHON	SELEROSIS	YEAR	٠٤.
	ם פ	Iner	if any, leading to immediate Cause. Enter Underlying Due to (or as a consequence of):	and a start Dicz	THE YE	
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	29 MLICKY DISE	MSC /EAR	5
Š,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit		. Substitution of the subs	•		
00	ificate g phys	edical	d	-		
Y D D	h cert ending	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery	
	e deat he att	sicis	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day	Year
<u>.</u>	w requires that the death certific been signed by the attending p should be detached for use as		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resiting in the.	underlying cause given in Part I 23e [Did tobacco use contribute to the cause of	death?
cords,	signe d be	d by	Heart Transplan			Onknown
5	s beer shou	lete	Periphral Vascy	lar Decare 24a. V	Vas an 24b. Were autopsy findings	available
ב	The la	Completed	COLOCTOMY		utopsy prior to completion of of death?	cause of
מ	lan: prtifica etor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check or		
2	hysic this ce at dire	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Residence 6 Other (Specify)	
	ding F	llon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No 28d. Descri	be how injury occurred	
2	Atten deatl octor: y the	flca	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office 28f. Location	on (Street and Number or Rural Route Num	nber,
Ś	s after s after od in b	Certification:	4 Homicide determined building, etc. (Specify)	City or	Town, State)	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	edlcal (29a. Certifier (Check only (Ch	th occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated. ne, date and place, and due to the cause(s	s)
	othe vithin 2 othe omple	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	- s - o		1 my	D44996	December 2 2	005
f			30. Name and address of person who completed cause of death (Item 23a) (Type	D44996 311 Lappans Rd 13	Dinchon Man 1)	117
5 h	1-24+1			311 W 1119 111 20 15		/ _3
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 2 2005 32. Registrar's Signature	perte		

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and Death		gieńeUUJ Rog. No.	40461
100	100		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
F	hysici/ Medio/		Esther Virgini	a Uhl				Decemb		005 17:50 PM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dea	th	4c. County of E	
		e)	Memorial Hosi 5. Social Security Number 6. Sex	Dital	. last birthday)	If Under 1 Year	If Under 24 Hrs	1 d		Birthplace (State or Foreign
100	uneral rector			м жж 79	Yrs.	Months Days	Hours Min		ў _{Үеаг)} 6 1926 М	Country) aryland
D D	40 00		Usual Residence of Decedent							
anyfan	wow.	١	10a. State 10b. County Allega	-	ity, Town or Lo Wester	_				10d. Inside City Limits 124 es 2 ☐ No
he M	CHITTE CHITTE	Director		шу	Webler	10f. Zip Code			10g. Citizen of Wha	
with	a or 3	급	10e. Street and Number 207 Central Av	e.		2156	2		United	· ·
death	ma 23	Funeral		12. Was Decedent Ever in t	J.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-	- 14. Race - A	American Indian,
.0036 hours after death with the Maryland	item 27 is marked other then *nature!, or items 23s or 28s-f ehow other treumstic event, the Modical Exeminar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🎛 📆 idowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:		f Yes, specify Cubi 1 ☐ Yes 2 XX io	Specify:	no Hican, etc.)	Specify:	White, etc. White
21215-0036 id within 72 hours afl giene.	natura lical	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	ation	orkina	16b. Kind of Busin	ess/Industry
.1215- within 72 ene.	Men a	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired ecretary	3)	9	School	System
d 212	nt.	Ö	12 17. Father's Name (First, Middle, Last)			2	18. Mother's Na	me (First, Middle.	Maiden Sumame)	
arylanc should be f	rked of	To Be		lichael			Lora		oadwater	
Maryland nd 2 should be file Ith and Mental Hy	27 is mar treumat		19a. Informant's Name/Relationship (Type Steven Uhl / son	oe, Print)					er, City or Town, State ax, Virgi	
altimore, M	t: if item /		20a. Method of Disposition 1 ★ Warial 2 □ Cremation 3 □ R	amount from State		sition (Name of natory or other place	(e) 12/ 20	Date 06/	20c. Location - City Westernpo	or Town, State
altin mit. P. partme	Important: if it any injury or o	H	4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License			. Name and Addre		oal Fune	ral Home	
m & &	EES		7. Wayne	Dock					rt, Maryl	and 21562
			23a, Part1. Enter the disease for compli- shock, or heart failure. List only on	e cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between
1	sician		Immediate Cause (Final disease or condition resulting in death)	ACUTE K	ESPIR	ATORY	+ AILU	RE		Onset and Death
	edical miner		resulting in death)	Due to (or as a conse	quence of):	Toou	= 444 A			INAV
#	To Alexander	e	Sequentially list conditions, if any, leading to immediate	ue to (or as a conse	quence of):	I SCH	EMIA			TDIE
pen	ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	ATRIAL	- Fi	BRILL	ATIO	V		MEAR
o exec	en an rial-tr	Еха	resulting in death) Last	Due to (or as a conse	quence of):					1
8 760, cate be executed	physicien and the burial-transit	dicai		SIKU						IMONTH
		/Mec	IF FEMALE:	3c. If yes, outcome of pregn	nancy				22d Date of	dolinos
. BOX 6	by the ettending tached for use a:	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of Month	Day Year
o 🖁	oy the	hysi	1 ☐ Yes 2 🖾No 9 ☐ Unknown	9□ Unknown	. 141					
<u>- ~</u>	s been signed to should be deta	by P	Part I. Other significant conditions con				en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
	en sig	ted	INEUMONIA,			ION		1 🗆 Y	/es 2.23No 3⊡	Probably 4 Unknown
		Completed	THROMBOE	MBOLIS	M .			24a. Was autop	sy prior	autopsy findings available to completion of cause of
	pag	Con							rmed? deat	n? Yes 2⊠No
Of VITAL HECOFGS, Physician: The law requires t	is certificate ha director, page 2	Be	25. Was case referred to medical examiner?	ospital:		t 20 DOA Oth	or	ath (Check only o		
o ę	0 0	: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a, Date of Injury	28b. Time of	1 3L DOX	4 🗆 Hursing i		dence 6 Other (S	Specify)
VISION Attending r death.	r: After the funeral	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No			
DIVISION i or Attending efter death.	Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec.	nome, farm, str	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
Hospital or 24 hours efte	led ir									
• Hospitai 24 hours 6	Funerel Dir letely filled in	edical	29a. Certifier (Check only 2 Medical Examir one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tire restigation, in my o	ne, date and plac pinion, death occ	e, and due to the ourred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the I	To the	Me	29b. Signature and title of certifier	A	<u></u>	29c. Licens	e number		29d. Date signed (M	onth. Day, Year)
r >	,- 0		> Seusalunt	Namals,	/	175	865.5		12/3/	05
1	2		30. Name and address of person who co			Print) Grantsvil	Jo. MD.	21536	1	
			Dr. Sabahat Nawak		e Dr.		Te,			
	Sta Registr		31. Date filed (Month, Day, Year) $DEC - 5 2$	32. Registrar's Sign	A A	backs				

Physiciar /Medica Examine

Funeral Director

		_ For	Plea		-			d / Dep	oartme	ent of I	. Ensur Health a				_	le.	01.	60
	•	1 - State Registrar						Ce	ertifica	ate of	Death			Reg. No.	CUL	- 14	UH	02
icia	an	1. Decedent's Name	e (First, Middl	e, Last)									2. Date of D Month	Day		ear		ne of Death
dic		Muriel	Ноо		Atwo		_			ridge			Nov.		2005	D 15	9:	30 P M
nin	er	4a. Facility Name (f				mber)				ockvi	or Location of	Death			County of ntgo!		r	
اه.		Shady Gr		6. Sex		7. Age	(In yrs. i	last birthda	y) If Un	der 1 Year	If Under 2		8. Date of B	irth		. Birthp	lace (St	ate or Foreign
al or		579-48-14	444	1 🗆	M 2 ∑ F		96	Yrs.	Month	ns Days	Hours	Min.	(Month, D April	26 , 1	909	New New	Yor	k
	Ì	Usual Residence of 10a. State	Decedent 10b. County	-			100 Cib	y, Town or	Location							1	Od Insid	de City Limits
	5							ckvil.								'		Yes 2 □ No
Colonia	ect	Maryland 10e. Street and Nur		mery			KOO	CKVII		Zip Code				10a. Citi	zen of Wh	at Cour	ntry?	
0.00		299 Hurl		nue							0850				U.S			
	Jera	11. Marital Status	<i>cy</i> 1100		2. Was Dec		rer in U.	.S. 13	B. Was De	cedent of	Hispanic Origi oan, Mexican,	in? (Spec	cify Yes or N	10-	14. Race -	Americ White,		in,
00000	Ē	1 Never Marri	_	-	Armed Fo 1 ☐ Yes If Yes, Gir	2X No)			2 🔯 No		1 46110 1	iloan, etc.)		Specify:	Whi		
1	d b	3 X Widowed			Year or D	Dates:		1 10 0						1 401 16				
1	iete		15. Deceder ify only highe	st grade	completed)			(Giv	edent's U ve kind of . DO NO	work done	during most	of workin	g	16D. KI	nd of Busi	ness/in	dustry	
	Completed by Funeral Director	Elementary/Seco 12			College (1-4or 5+))		Home	Make	er)wn H	ome		
	Be C	17. Father's Name	(First, Middle,	Last)							18. Mother	's Name	(First, Middl	e, Maiden	Sumame)			
	ToE	William 1	Hooker	Atwo	ood						Mehet	abel	G1e	nney				
		19a. Informant's Na							-	•	t and Number			-				
1		Judith G		Daugi	nter		anh B	6120 Place of Dis			, N.W.		hingto		cation - Ci			
b		20a. Method of Disp	Cremation		moval from	State	C	ropo1	rematory o	or other pla		ov. 20	28,			•		
		* 4 ☐ Donation 21. Signature of Fu				<i>A</i>	riet								K., V Home		LIIIa	
ouce.		1	2201A	P	7/1/4	0					ess of Facility 2222 W Washin	iscoi	nsin A D.C.	ve., 200	N.W.			
an al		23a Part Enter t el ock, or hea Immediate Cause disease or condition resulting in death)	irt failure. Lis (Final	r complice t only one	Pne	each line umon	ia											i Between and Death
er	licai Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	injury s	b. c. d.				uence of):										
	Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23	ic. If yes, ou 1 Live I 4 Pregu 9 Unkn	birth 2 nant at ti	Feta	death 3	3 □Ectopie 5 □ Other		су				23d. Date o Month		ery Day	Year
	d by Ph	Part II. Other signi	ficant condit	ions cont	ributing to d	death but	not res	ulting in the	underlyin	ig cause g	iven in Part I.			tobacco u		ute to th		of death?
,	ompiete												24a. Wa auto per 1 Yes	opsy formed?	dea	ath?	psy findi mpletion 2X No	ings available of cause of
	0	25. Was case refer	rred to medica	al							26. Place	of Death	(Check only					
	To B	examiner? 1 ☐ Yes 2X		H	ospital: 1 🔀	Inpatient	t 2 🗆	ER/Outpat	ient 3	DOA O	ther: 4 🗆 Nur:	sing Hor	e 5 Res	sidence	6 Other	(Specif	y)	
	lon:	27. Manner of Deat 1 XNatural	5 Pendi	ng igation	28a. Date (Mor	of Injury oth, Day	Year)	28b. Time Injury		28c. Inju	uryat ork?]Yes 2 ☐ N		8d. Describe	how injur	y occurred			
	Medical Certification:	2 Accident 3 Suicide 4 Homicide	6 Could	-	28e. Place build	e of Injur ling, etc.	y - At ho (Specif	ome, farm,		1			8f. Location City or To	(Street an own, State		or Rura	Il Route	Number,
	dicai	29a. Certifier (Check only one)			er: On the b		examina				time, date and opinion, death							ıse(s)
	Me	29b. Signature and	title of certifi)			29c. Licer	nse number			29d. Dat	e signed (Month,	Day, Ye	ar)
					w	/ 2	5	- , m	0	D00	57124			Nov	. 27,	20	05	
		30. Name and add			npleted cau	ise of dea	ath (Iten	n 23a) (Typ	e, Print)	m	0		100	2007	1.	-		
		Truong 1									Germa	ntow	n, MD	208/	4			
Sta istr		31. Date filed (Mor	NOV 3		05 32.	Pegistrar	s signa	de A	heel	9								

Registrar

Ronald L. Wise 05-8269

AKG

3269		•	1 - For Unpend Item	23a,27,	of Maryla 28a-f	nd/Depa	artment 1850 Tillicate	of He 2-15 of D	ealth a Death	nd Mo tas	ental Hy	giene	005	40	463
	Dharaisi		1. Decedent's Name (First, Middle,	Last)							2. Date of De.	ath Day	Yea		ne of Death
	Physici /Medio	_	Ronald		Lynn	1	Vise				Decembe				50 P M
	Examin		4a. Facility Name (If not institution,	•			4b. City, To			f Death		4c.	County of De	ath	
,			2261 West Balti			n lant hirthday		1tin	nore	D4 Hrs	P. Date of Bird	n/a		inthology (Cr	nda on Consissa
7	Funeral Director		5. Social Security Number 218-64-9778	6.Sex 1∭ M 2□ F		s. last birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da 11/27/19	y, Year)		Country) ryland	ate or Foreign
9			Usual Residence of Decedent		52						11/2//19	73	ria	Lyrand	
	ylanc how		10a. State 10b. County		10c. 0	City, Town or Lo	ocation								de City Limits
	the Marylan 28a-f show	cto	MD N/A			Baltimo	re							1 1 1	Yes 2 ☐ No
	ith the	Dire	10e. Street and Number				10f. Zip C	ode				10g. Citi	zen of What (Country?	
	• 23e	Funeral Director	2261 West Baltin		t cedent Ever in	11.0		21223		-i=2 (Caa	afe Van as Na	US	A 14. Race - An	nariosa India	
	item de	n.	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed F	orces?	71 .	If Yes, specifi	y Cuban	, Mexican	, Puerto F	ofy Yes or No- lican, etc.)	•	Black, W		ırı,
936	hours after death with the Maryland tural; or iteme 23a or 28a-f show al Examiner must be nutified at	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, G Year or I	2□No 19 ive Dates: 19	72	1 Yes 2	∏ No	Specify:				Specify:	√hite	
21215-0036	n 72 hours "natural", adical Exe	Completed	15. Decedent's (Specify only highest	s Education		16a. Dece	dent's Usual	Occupat	ion	of workin	a	16b. Ki	nd of Busines	s/Industry	
21	within the the Mer	npie	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use	retired)	g 111031	0, 10,1111	9				
	led w lygier her th		12	2		Shee	t Metal			de Nome	(First, Middle,		onstruct	ion_	
and	ntai H	Be	17. Father's Name (First, Middle, L Kenneth D	allas	IJ.	ise			Virg			Lee		anson	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than "reumatic event, the Mar	2	19a. Informant's Name/Relationsh				na Address (Street an			Route Numbe				
S	s 1 and 2 should be filed within 72 hours after death with the Maryla of Heelin and Mental Hygiene. If the 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Maulical Examinar must be notified at					Service Co.					mberland				
re,	f Hee f Hee item		Virginia L. Moore 20a. Method of Disposition			Place of Dispo	sition (Name	of			ate		cation - City		te
Ę	Peges lent of nt: if it ry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation _ 5 ☐ Other (Sp		State MD	Vet. Cen	•		1	2/12/	2005	Fli	ntstone,	Maryl	and
Baltimore,	permit. Peges Department of Important: If ii eny injury or o		21. Signatur , of Freneral Service L	icensee							ns Famil				
m	88 5 8	00 1	I tohut C	- Cel	en		404 Dec	atur	Stree	t, Cur	mberland	, Mar	yland 2	21502	- 1
	Physician		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	complications that inly one cause on	caused the de each line.	ath. Do not en	ter the mode	of dying,	, such as	cardiac or	respiratory ar	rrest,		Approx Interva Onset	timate I Between and Death
	certificate be executed by a continuous physicien and continuous as the burial-transit continuous	ical Examiner	Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	(or as a cons										
B.	death certific a ettending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live	utcome of preg birth 2 Fe nant at time of nown	tal death 3	⊒Ectopic preg ⊒ Other (spec					2	23d. Date of d Month	elivery Day	Year
, P.O.	requires thet the sen signed by th rould be detache		Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cau	ise giver	n in Part I.		23e. Did to	obacco u	se contribute	to the cause	of death?
Division of Vital Records,	w requires been sig should b	Completed by									101	Yes 2[□No 3□1	Probably	4 Ninknown
9	aw is by	piet									24a. Was		24b. Were	autopsy find	ings available of cause of
<u>=</u>	The cate ha	Con	11.05									rmed? 2 No	death'		
/ita	icien: Sertific Sector,	Be	25. Was case referred to medical examiner?	Hospital						of Death	(Check only o	ne)			
of	Physicien: this certific ral director,	10	txxYes 2 ☐ No 27. Manner of Death	28a Date	of Injury	☐ ER/Outpatie		1	4 🗀 1401		e 5 Resident		Other (Sp.	ecity) a	t scene
o	ding th. : After fune	ţ	1 □ Natural 5 □ Pending 2 □ Accidentinvestigat	Found	Th, Day Year)	28b. Time of Found 5:12	'P M	Unjury a Work?	5° es 2.12271		ou. Describe i	iow intal	y occurred	Gara	
isi	Atten r deat octor; y the	ifica	3 ☐ Suicide 6 🛣 Could no	ot be 28e. Plac	e of Injury - At	home, farm, st			Т		8f. Location (S	Street and	d Nymberor	Bural Route	Saltimor
ă	s afta	Certification:	4 ☐ Homicide determin	Dulk	in res					S	t., Ba	vn, State, 1tim) 2201 ore, M	west n D	аттишог
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page:	edicai (29a. Certifier 1 Certifying (Check only one)	Physician: To the l xaminer: On the l and mai	e best of my k basis of exami nner stated.	nowledge, deat nation and/or in	h occurred at vestigation, in	the time	e, date and nion, deat	d place, a th occurre	nd due to the d	cause(s) date and	and manner place, and di	as stated. ue to the cau	use(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7		- W		License			- 1		e signed (Mo	-	
			larde	Hallo	u l	wd		o.c.	M.E.			Dece	ember 8	, 200)
-			30. Name and address of person w	no completed cau	ise of death (It	- 67		Stre	et,	Balt:	imore,	Mary	land	21201	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 4	2005	Angistrar's Sig	nature	and)								

		1 - State Unpend Item 2 Registrar 1. Decedent's Name (First, Middle, Las		061	incate	Dealli	2. Date o	f Death	70 7	3. Time of Death
Physic /Med		Loy L	ou	Wendrick	KS		Dece	mber 06,	2005	8:46 P
Exami	ner	4a. Facility Name (If not institution, give Sacred Heart Hosp			4b. City, Tow Cumber	vn, or Location of i rland	Death		ty of Death Legany	
Funeral Director		5. Social Security Number 6. Security Number 216-72-6380	7. Age (In 19 49	yrs. last birthday) Yrs.	If Under 1 Y Months Da		Min. 8. Date of Feb	25, 1956	9. Birthpla Counts	ice (State or Foreig
Č >	tor	10a. State MD Allegar		. City, Town or Lo Frostl	cation burg				100	d. Inside City Limit:
h with the 23a or 28e at be not	al Direc	10e. Street and Number 134 W. Main Stree	t		10f. Zip Coo	21532		10g. Citizen o	f What Countr	y?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "natural" or items 23a or 28s-f show eny injury or other traumatic event, the Madical Examinar maint be maillised at appear.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	li	Vas Decedent Yes, specify (of Hispanic Origin Cuban, Mexican, F No Specify:	? (Specify Yes or Puerto Rican, etc.		ace - Americar ack, White, et ify: white	C.
Baltimore, Maryland 21215-0036 semil: Pages I and 2 should be filed within 72 hours att oppartment of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "natural; or ny injury or other traumatic event, the Madical Exemplate."	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life. L		ocupation one during most of tired)	f working		Business/Indu	,
/land Juld be fited Mental Hygurked other	To Be C	17. Father's Name (First, Middle, Last) William Ware						ddle, Maiden Suma derson W	ime)	- 45
and 2 sho		19a. Informant's Name/Relationship (T. Clifford Wendricks					or Rural Route Nu Cur	mber, City or Town nberland	n, State, Zip C	21502
imore Pages 1 ment of He ent: If itar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State S	b. Place of Dispos cemetery, crem Carpelli Fui	sition (Name of latory or other neral Hor	ne, P.A.	Date 12/10/2	20c. Location 005 Cresa	- City or Towr ptown	n, State MD
Ball permit Depart import eny inj		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or comp shock or head failure it come	1 Scarpl	W.	108 V	leffr	nue: Cumb	erland, MD	21502	
Wedical cale be executed by sician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	sequence of):	USCIEI	ocic care	iiovascu	iar visea	ise	
Records, P.O. Box 68 The law requires that the death certilical the has been signed by the ettending phy page 2 should be detached for use as in	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 🗆	Ectopic pregna Other <i>(specify)</i>		- 37' -		ate of delivery onth Da	y Year
Cords, P	ed by Pl	Part II. Other significant conditions con	tributing to death but not r	resulting in the und	derlying cause	given in Part I.		id tobacco use con	tribute to the o	44
	e Completed	25. Was case referred to medical					10 Yes	a 2 □ No	death?	findings available etion of cause of
of Vital Physician: this certifice ral director,	ToB	examiner?	ospital:	ER/Outpatient	3□ DOA		Death Chéck on	y one) esidence 6 □Ott	(Cif i	
After		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a Date of Injury (Month, Day Year)		28c. In	ljury at Vork? Yes 2 No	28d. Describ	e how injury occur	red	
DIVISION To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe				City or 1	(Street and Numi Fown, State)		
DIVI To the Hospitel or At within 24 hours after or To the Funeral Direc completely filled in by	Medical	one)	sician: To the best of my k ler: On the basis of exami and manner stated.	nowledge, death on nation and/or inve	occurred at the estigation, in my	time, date and pl y opinion, death o	ace, and due to the	e, date and place,	anner as state and due to the	d. e cause(s)
Vith To 1	2	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month, Day	r, Year)
,		So. Name and address of person who co	(/ MA) mpleted cause of death (it	em 23a) (Type, P	orint)	.C.M.E.		Decem	r 07,	2005
		Pamela E. Southa								

			1 - For State Registrar		of Maryla	nd / Depa	artme		lealth a	and M		giene Reg. No. (005	•	0465)
	Physici	an	Decedent's Name (First, Middle,							Date of Death Month			Yea	r	3. Time of Dear	
	/Medi	cal	REBECCA 4a. Facility Name (If not institution,	MOLFE			45 C	h. Tour	t continu	of Death	BHSVOY	-1-	County of De		10:45	- M
	Examir	ner				-		ty, Town, or ŒN	BUR	9			IN AR		D == 1	
7 .	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Und	fer 1 Year	If Under	24 Hrs.	8. Date of Birt	1 120	9. B	irthplace	e (State or For	eign
В	Director		217-44-5739	1 □ M 2 💢 F		61 Yrs.	Month	s Days	Hours	Min.	8. Date of Birt Jan I Z	, Year) 9	44	Country)	e (State or For Florida	a
	pu *		Usual Residence of Decedent 10a. State 10b. County		100 C	ity. Town or Lo	nation							101		
	sho	5	,	Arundel	100.0	Odento:									Inside City Lin 1 X Yes 2 □	
	28a-1	ect	10e, Street and Number			- Odeliteo		Zip Code				10g Citize	en of What			
	3a or	ā	8608 Wandering	Fox Trai	1 Apt#1	.05		2111	3				SA	Journay :	,	
	within 72 hours after death with the Maryland sne. than "natural", or Itema 23e or 28e-f show is Madical Examinat Fibel De notified at	by Funeral Director	11. Marital Status		1 □Yes 2 □XNo		Was De	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F			ecify Yes or No-	14	14. Race - American Indian,			
စ္	or Ite	/Fu	1 Never Married 2 Marne					2EXNo		і, Риепо	Rican, etc.)	hite, etc.				
8	ural',	d b	3 ☐ Widowed 4 🛣 Divorced	Year or D	Year or Dates:									White		
7	n 72 nnat	Completed	15. Decedent's (Specify only highest	grade completed)	te completed) (Give k			sual Occupa vork done d use retired	turing most	t of work						
12	withi iene. than	шо	Elementary/Secondary (0-12)	Coltege ((1-4or 5+)	,,,,,,	Own		/			Auto	кераз	Lr B	usiness	>
Maryland 21215-0036	Hyg other	Be C	17. Father's Name (First, Middle, L	ast)			- 1111		18. Mothe	r's Name	(First, Middle,	Maiden S	umame)			
<u>lar</u>	Aenta Aenta rked tic ev	To B	Frealin McAdoc	Qualls					Jacq	ueli	ne Lee	Mitcl	ne11			
an	and h		19a. Informant's Name/Relationshi								al Route Numbe			Zip Co	de)	
	and ealth m 27		Heather Kimball	./ Daught							Laure	1, MI	207	724		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinating the nutitied at ance.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	3 □Removal from	Jake	Place of Dispo cemetery, crer					Date		ation - City o		State	
E	t. Pa rtmen rtant: njury		4 Donation 5 Other (Sp.		Hu	intt Cr		-			8/2005		Ldorf,			
<u>a</u>	Dep Impo any		21. Signature of Funeral Service L	2000		10	Name 5000	Anna	s of Facilit	y Rob Roa	ert E. d Bowie	Evans . MD	Fune 20715	ra1	Home	
E	nysician /Medical Examiner	Physician/Medical Examiner	23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)									12	proximate erval Between iset and Death HOURS			
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		d										MONT	-24		
		ysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4∐Pregr 9☐ Unkn	nant at time of one of the community of	death 5	Other (specify)					Month Day Year			
مز	Physician: The law requires that the this certificate has been signed by the tail director, page 2 should be delach	H.	Part II. Other significant conditions contributing to death but not resulting in the underlying car						n in Part I.		23e. Did to	23e. Did tobacco use contribute to the cause				
Records,	puires tha n signed ild be del	d by									1 No 3 Probably				4 □Unkno	wn
ဝွ	s been si	jete	24a.								24a. Was a	Was an 24h Were auto			findings availa	ble
Re	The its	Completed									autops	ned?	prior to death?	comple	ition of cause of	of
ā	ian: rtiflica stor, p	BeC	25. Was case referred to medical						26. Place	of Death	Check only or		- T - T - T	s 2 _	1140	
>	nysic nis ce I direc	To	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2	Other					Home 5 ☐ Residence 6 ☐ Other (Specify)					
0	ng Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury		28c. Injury Work	at ?	2	28d. Describe h	w injury o	occurred			
<u>s</u>	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be						fes 2□N							
Division of Vital	after death after death Director: , d in by the f	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ry, office 28f. Location (Street a. City or Town, State			reet and l 1, State)	nd Number or Rural Route Number, e)			
	To the Hospital or Attending Physician: The lav within 24 horus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E.	Physician: To the xaminer: On the b and man	e best of my knopasis of examination	owledge, death ation and/or inv	occurre estigation	d at the tim on, in my op	e, date and inion, deat	d place, a h occurre	and due to the c ad at the time, d	ause(s) ar ate and pl	nd manner a ace, and du	s stated	f. cause(s)	
	To the To the To the Comp	Me	29b. Signature and title of certifier				2	9c. License	number		2	9d. Date s	signed (Mor	th, Day,	Year)	
			Giliamos Giongras, MD					D0065714 NON					EMBER 26, 2005			
			30. Name and address of person w			m 23a) (Type,		WILLIAM ST								
			22.324.41.4	OSE CIT	HCBEC		116	10-11	M TA	341	CLENT	4908	14,5	,2	1201	
1	Sta Registr		31. Date filed (Month, Day, Year)	9 2005	Registrar's Sign	ature	An	1								

			1 - For State Registrar	_	aryland / De	partment of I ertificate of	Health and	Mental Hyg			40466			
	Physici	an	Decedent's Name (First, Middle, La.			-		2. Date of Dea Month	_	Year	3. Time of Death			
	/Medi	cal	Michael	J	_ wel			November			9:00 p. M			
Į.	Examir	ier	4a. Facility Name (If not institution, given 1733 Heather Lane		4b. City, Town, o	or Location of Dea	ath	4c. County of Death Frederick						
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthd			IS 9 Date of Righ			R pplace (State or Foreign untry)			
+	Funeral Director		S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 217-42-1888 Usual Residence of Decedent											
	within 72 hours atter death with the Maryland ene. than "naturel", or Iteme 23e or 28e-1 ehow ta Macical Exemirar must be muitled at		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits			
	Ba-f-	cto	Maryland Frederic	ek	Freder	ick			1 Pres 2 □ No					
	iff the	Dir.	10e. Street and Number		10f. Zip Code		0g. Citizen o	of What Cou	ıntry?					
	ath v	by Funeral Director	614 Maxwell Avenue			2170	1		U.S.	U.S.A.				
	er de	nue	11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		ace - Amer lack, White				
99	', or	Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		10	1□ Yes 2 No	Specify:		Spec	ifv				
우	hou	edt	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education			cedent's Usual Occur	antina			W	hite			
Σ.	in 72	Completed	(Specify only highest gra	(G	ve kind of work done DO NOT use retire	during most of w	rorking	16b. Kind of	Business/li	ndustry				
7	with iene.	l lilo	Elementary/Secondary (0-12)	College (1-4or 5	+)	ician	-,		Music					
0	Hyg othe	e C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M		ame)				
<u>a</u>	Med be	To Be	Frank Wells, Sr.					lcGuire		,				
Maryland 21215-0036	shound N	_	19a. Informant's Name/Relationship (7	Type, Print)	19b. Ma	tiling Address (Street			City or Tow	m, State, Zi	p Code)			
Σ	alth a		Nancy MacNamara -	Friend	1733	B Heather	Lane, Fr	ederick,	Maryla	and 2	21702			
ē,	t tem Item othe		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place	ogi L	Date	20c. Location	n - City or T	own, State			
Ĕ	Page Tent of Int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			k Cremato		9-2005 _F	rederi	ick, N	Maryland			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In proportant: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-1 show eny injury or other traumatic event, the Miscical Extending must be nutified as once.		21. Signature of Funeral Seririce Licen	see No	-	22. Name and Addre	ss of Facility S+	auffer Fu	neral	Ното				
m	\$0 E E 8		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 2170											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
ij.	Physician		Immediate Cause (Final disease or condition as Property of the Condition of double of the Condition of the C											
ž.	/Medical		resulting in death) Due to (or as a consequence of):											
	Examiner		Sequentially list conditions, b											
	D #	Examiner	If any Leading to immediate Due to for an a nonseculance of Cause (Disease is filled)											
	ecute and trans	cam	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):											
760,	ate be executed hysician and the burial-transit													
8	death certificate be executed e attending physician and od for use as the burial-transit	dicai		d										
œ ×	eath certific attending pl	Physician/Med	IF FEMALE:	220 16.000 0.400										
Rox	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of delivery Month Day Year				
J.	at the de by the a tached	ysic	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death	Other (specify)			ľ	Ontri	Day Tear			
J.	The law requires that the sie has been signed by the sage 2 should be detached.			on in Port I	22a Did tab									
Hecords,	ires that signed t d be det	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba								he cause of death?			
Ö	w require been sig	Completed								3 FIOL	Jabiy 4 DOTKHOWN			
ě	The iaw bete has page 2 s	E I						24a. Was an autopsy		. Were auto	ppsy findings available mpletion of cause of			
								perform 1 ☐ Yes 2		death? 1 ☐ Yes	2 No			
or vital	icien: certifice rector, p	Be	25. Was case referred to medical examiner?	Hospital:		104		ath Check only one)					
5	Phys this al dir	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🗆 Inpatier	t 2 ER/Outpati		4 🗆 Nursing r	Home 5 Resider		TITCHU S				
	ding F	<u>[</u>	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor	k?	28d. Describe how injury occurred			Residence			
25. Was case referred to medical examiner? 1														
28d. Describe how injury 28d. Describe how									State)	iber or Rura	tl Route Number,			
_	spita nours nerel filled		29a. Certifier 11 Certifying Phy	rsician: To the best of	my knowledge de	ath occurred at the ti-	ne data and als	a and due to the	122(2) - :					
	To the Hospital or within 24 hours after To the Funerel Director completely filled in b	edicai	(Check only 2 Medical Exam	iner: On the basis of and manner stat	examination and or	investigation, in my o	pinion, death occi	e, and due to the car urred at the time, dat	use(s) and m te and place,	anner as s , and due to	tated. the cause(s)			
29b. Signature and title of certifier 29c. License number									d. Date signe	ed (Month.	Day, Year)			
D 32245								1	_		2005			
	1.1	+	30. Name and address of person who c		-		2210		, (00	1	<i>y</i> 5			
U	41		Dr. Amy Jones			son Dr. F	rederick	, MD 2170	2					
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0	32. Registr		South .								

			For State Registrar	State of	Marylan		artmen rtificate				lental Hy	giene	005	1; (046	7
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	eath Day	y Ye	ar 3.	. Time of E	Death
	/Medic		Helen M. Wiley								12	05		- 0	440_	A ^M
	Examin		4a. Fecility Name (If not institution,		•				Location	of Death			County of E			
			Frostburg Village 5. Social Security Number 6		Hone Age (In yrs.	last birthday)	If Under	ostk 1 Year	ourg If Under	24 Hrs.	8. Date of Bi	rth	Alleg		/State or	Foreign
	Funeral Director		213-24-5731 Usual Residence of Decedent	1□ M 2 X 0 F	77	Yrs.	Months	Days	Hours	Min.	(Month, Di March 2	ay, Year)	28 M	Birthplace Country) aryla		, oroign
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. J	Inside City	y Limits
	Man,	tor	Maryland Garrett		G	rantsv	ille							1	1 🗌 Yes	2 🔀 No
	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show Jisel Examiner must be notified at	Directo	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wha	t Country?		
	23a c		82 Railroad Street						21536							
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?			.S. 13.	Was Deced	ent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Amer Black, White					
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give	2 ₹ No		1 ☐ Yes 2	No X	Specify:				Specify:	• •		
Ö	hour turel	ed b	15. Decedent's		par or Dates:			I Occupa	ation			16b K	White Kind of Business/Industry			
5	in 72 n "na nedic	plet	(Specify only highest	grade completed)	4	(Give	kind of wor DO NOT us	k done d	furing mos	t of worki	ng	100.10	TIG OF DUSIN	03311100311	1	,
212	d within jiene. r then "	Completed	Elementary/Secondary (0-12)	College (1-	40r 5+)	Libr	arian	1				Gran	tsvil	le El	.em. ^S	choo.
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or liems 23a or 28e-f show event, Ita Macical Examinar must be notilised at	Bec	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)			
/lar		5	Edwin Ray Billme	eyer					Bes	sie (Catheri	ine Y	aste			
lar,	2 should be and Mental Is marked and warked and and and and and and and and and an		19a. Informant's Name/Relationship	p (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	A Route Numb	er, City o	r Town, Sta	te, Zip Cod	de)	
	D = F = B		Lori A. Kyle/dau	ighter					w Ro		Grants			2153		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3	B □Removal from S		Place of Dispo cemetery, crea	natory or o	ne of ther place	θ)		ate	20c. Lo	ocation - City	y or Town,	State	
Ë	tmen tant:		`4 ☐Donation 5 ☐ Other (Spe		Grai						,2005		ntsvil	lle, N	MD	
Bal	permit Depart Import any in		21. Signature of Funeral Service Li	censee	/	Ň	i Name an Iewman	Addres Fur	is of Facili	ty Home	es, P.A	A.				
	du = e d	\vdash	23a. Part 1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
			shock, or heádt #ailure. List only one cause on each line. Interval Battween Onset and Batth											/een		
	Pnysician /Medical		disease or condition resulting in death) a. a. a. a. a. a. a. a. a. a. a. a. a. a									ks				
	Examiner		Due to (or as a consequence of):													
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Linderlying Cause (Disease or injury that initiated events c.								-					
	nsit	듣														
8760,	ate be executed hysician and the burial-transit	Examine	resulting in death) Last Due to (or as a consequence of): d.													
	ate be nysicia he bur	lcal											10			
Ö	tifica ng ph as th	led	JE SOULS													
Вох	death certific e attending p ed for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of		. V			
	s deal	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify)								Month Day Year			ar .		
P.0	at the de d by the etached	Phy								00 - Did					- 1 - 0	
ŝ	The law requires that the tte has been signed by thoage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc 1								3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown					
orc	w require been sig should b	eted														
ec	e law has b	nple								psy	24b. Were autopsy findings available prior to completion of cause of					
alF											ormed? death? 2 No 1 Yes 2 No					
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	1.0		(Check only					
of		. To	1 Yes 2 No 27. Manner of Death	1 ∐In 28a. Date of		ER/Outpatier 28b. Time o		A	4 NI			Residence 6 Other (Specify)				
	ding f h. After funer	tlon	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 Accident investigation (Month, Day Year) Injury M 1 Yes 2 No								w wildly observed					
Division	l or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could no	t be 28e. Place of	28e. Place of Injury - At home, farm, street, factory, office						28f. Location (Street and Number			or Rural Rol	ute Numb	er,
á	after I Direct din by	ert	4 Homicide determined building, etc. (Specify)							City or To	wn, State)				
	e Hospitel or 124 hours after e Funeral Directel birectel	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the la xaminer: On the ba	sis of examina	owledge, deat ation and/or in	h occurred avestigation,	at the tim	ne, date an pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manne I place, and	er as stated due to the	i. cause(s)	
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	a - 2			290	. License	number			29d. Dai	te signed (N	fonth, Day,	nth, Day, Year)	
	F ≤ F Ö		> norsocki	Shin	MD		1	000	5532	25		ne	0 0	5 20	705	
	1 =		30. Name and address of person w	ho completed cause	of death (Item	n 23a) (Type.						UC	- 03			
	12		WONSOCK SHIN		8 Tarn			705	Howa	29 1	40210	532				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa					0						
	Regist	rar	DEC - (5 2005	Ester	A. A	Lord	No.								

ORIGINAL

DHMH 17 Rev 1/2001

JC

			For State Registrar	State of Marylan			of Health an of Death	d Mental I	lygiene Reg. No		40469
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Month	Death Day	v Year	3. Time of Death
	Physici /Medic		Patricia	Ann	Ţ	Mhite				3. 2005	1:46A. M
100 mg	Examin	_	4a. Facility Name (If not institution, give	e street and number)		4b. City, To	vn, or Location of D	Death	4c.	. County of Death	1
		de .	Memorial Hospita	1			Cumber1a			Allega	
-7 Y	Funeral	-:	Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Y Months D		Min. 8. Date of (Month	Birth Day, Year)	9. Birth	nplace (State or Foreign untry)
	Director		214-46-3599	61	Yrs.			10/05	/1944	Mary	land
	and w	1	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ö	ND 411		T	root hure					1 ☐ Yes 2 🕅 No
	288 Inc.	Director	MD Allegany 10e. Street and Number		r	rostburg 10f. Zip Co			10g. Cit	tizen of What Cor	untry?
	3a or		100 Honeysuckle	Lane			21532			USA	
	filed within 72 hours after death with the Maryland Hygiene. ther than instural; or terms 23e or 28e-f show ent, the Medical Examinat must be notified at	by Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Deceden	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes o	No-	14. Race - Amer	
S	after of the land	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				ruerto Hican, etc.	,	Black, White	, etc.
ဇ္ထ	ours a	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2🏋	No Specify:			Specify: W	nite
21215-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual C	lone during most of	f working	16b. K	ind of Business/l	ndustry
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use i	etired)				
7	led w lygier her ti		12 17. Father's Name (First, Middle, Last,	2		Secretar	-	Name (First, Mid		e and Rub	ber
Maryland	be fi	Be			D.,	rkett	Zuma		Mary		iner
ž	d Mer nark	유	William 19a, Informant's Name/Relationship (Edward			treet and Number of				
Nai	d 2 st h and 7 Is r traur		Billie Sue Lyzbicki		1		, Somerset,			5, 70WH, Olato, 2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
a)	1 and 2 Health tem 27 I		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name	of	Date		ocation - City or	Town, State
Š	Pages nent of h ant: If its		1 🖾 Burial 2 ☐ Cremation 3 ☐	IRAMOVALITOM State		matory or othe	rplace) Gardens 12	/07/2005	Ta	Vale, Mar	zl and
Baltimore,	그런근금 .		4 □Donation 5 □ Other (Specification of Fun ral Service Licer				Address of Facility	-0.00			
Ba	Depa Depa Impo any i		1/12/0	20 6)		atur Street		,		•
			23a. Part1. Enter the disease, or com	plications that caused the deal	h. Do not en	ter the mode of	f dying, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Between
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		1-00	210				Onset and Death
8	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq	uence of):	lero	217				19cs
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	cuted nd ransit	Examine	Cause (Disease or injury that initiated events	с.							
Ö,	e exe ien al urial-t		resulting in death) Last	Due to (or as a consec	juence of):						
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, W	eath certific attending p	Me	IF FEMALE:	22a li van autoama oi progra	2001						
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0	at lhe de by the a stached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	ieam st	_ Other (speci	iy)				
٥.	that II ed by detac		Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cau	se given in Part I.	23e. l	Did tobacco	use contribute to	the cause of death?
of Vital Records,	Se Log	d by							Yes 2	□No 3□Pro	bably 4 Unknown
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Re	The lay	п				·		— a	utopsy performed?	- death?	topsy findings available completion of cause of
a		ပိ	25. Was case referred to medical				26 Place of	1 ☐ Y f Death (Check o		1 ☐ Yes	212 No
⋚		OB	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Othor	ing Home 5□1		6 ⊟Other (Spec	rify)
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ion	nding 1 ath. r: After e funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	м	Work? 1 ☐ Yes 2 ☐ No				
Division	or Attendi after death. Director: A in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, st	reet, factory, o	ffice	28f. Locati City o	on (Street ar	nd Number or Ru	ral Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	edical	(Check only 2 Medical Exa	hysician: To the best of my knominer: On the basis of examina							
	To the P within 2- To the F complete	Med	one)	and manner stated.		290 1	icense number		29d Da	ate signed (Monti	n Nav Year)
			29b. Signature and title of certifier	/		230. 0					pute.
	2		1/r Ch.	V	- 00 \ =	Delai)	13676	0	Dece	ember -	2005
	nes		30. Name and address of person who	Proof !	m 23a) (Type		A	berland	mn.	21502	
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	1 - For State Registrar	State of Maryla			Health and		_	40470
Physician /Medical	Decedent's Name (First, Middle, Eva 4a. Facility Name (If not institution,	Elizabeth	Weyant	Ab City Town	or Location of Doc	2. Date of Deat Month December	Day Year 1, 2005	3. Time of Death 11:50 P
Examiner Funeral	Memorial Hosp	ital . Sex 7. Age (In yrs	s. last birthday)	Cumber1	If Under 24 Hr	's. 8. Date of Birth	4c. County of Dea	y rthplace (State or Foreig
Director	218-38-2383 Usual Residence of Decedent 10a. State 10b. County	1□ M 2⊠F 64	Yrs.	Months Days	Hours Mir	09/22/194		yland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event. The Medical Examiner must be routified at once. To Be Completed by Funeral Director		reet 12. Was Decedent Ever in Armed Forces?	Cumb	perland 10f. Zip Code 215	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No- into Rican, etc.)	0g. Citizen of What C USA 14. Race - Am Black, Whi	erican Indian,
s should be filed within 72 hours all and Mental Hygiene. Is marked other than "natural", or eumalic event, the Medical Example To Be Completed by F	3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Dates:	16a. Dece	dent's Usual Occu	pation	orking	16b. Kind of Business	White Vindustry
d 2 should be filed w ith and Mental Hygier 27 Is marked other tt treumatic event. the	12 17. Father's Name (First, Middle, La Harry	2 st) Elmore	Lice Frale	nsed Pract		ame (First, Middle, M		O'Hara
bermit. Pages 1 and 2 should be shou	19a. Informant's Name/Relationship Woodrow W. Weyant, 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 4 □ Donation 5 □ Other (Spe	Jr. / son ☐Removal from State cify) Cu	2817 C Place of Dispo cometery, crea	hurch Cree sition (Name of natory or other pla Crematory	ek Place, R	Date 204/2005	20c. Location - City or umber1and M	Town, State
Physician /Medical	23a. Part1. Enter the disease, or construction of the state of the sta	emplications that caused the deally one cause on each line. a. <u>Cardiac Arr</u> Due to (or as a conse	ath. Do not ent	+04 Decatur	r Street, C	Lumberland,	Funeral Home Maryland 21	502 Approximate Interval Between Onset and Death 2 hours
death certificate be executed be executed be executed by the extrement of the use as the burial-transit of iclan/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertensive Due to (or as a consect. Due to (or as a consect.)	e Cardiov	vascular Di	i sea <i>s</i> e			vears
death certific	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of preging the preging and a time of general at	tal death 3	Ectopic pregnanc	Sy		23d. Date of de Month	livery Day Year
es ti	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3 □ Pr	o the cause of death?
ician: The law requires to certificate has been signs rector, page 2 should be						24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Alter this certificate ha completely filled in by the funeral director, page Medical Certification; To Be Com	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could no	28a. Date of Injury (Month, Day Year)	X ER/Outpatien 28b. Time of Injury	28c. Inju Wa M 1	her: 4 🗆 Nursing	28d. Describe how	nce 6 Other (Spe w injury occurred	
spital or At ours after of neral Directilled in by	4 Homicide determine		eify) 		mo date est al	City or Town,		
To the Hospital within 24 hours a To the Funeral Completely filled	(Check only one) 2 Medical Expone) 29b. Signature) and title of certifier	aminer: On the basis of examinand manner stated.	nation and/or inv	estigation, in my	opinion, death occ	urred at the time, da	use(s) and manner as te and place, and due d. Date signed (Monti	to the cause(s)
1/2	30. Name and address of person wh	o completed cause of death (Ite	em 23a) (Type,	DO	9157		December 2, 2	
State Registrar	Paul Snow, 31. Date filed (Month, Day, Year) DEC 0 5	32. Registrar's Sign	nature_	et, Cumber	land, Mary	land 21502		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:15 pM Mary Jane Wilen December 6, 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 28, 1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Yrs. 62 **Director** 227-54-3300 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1XYes 2 No Directo Virginia Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 5904 Mount Eagle Drive, Apt. 1201 22303 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: ģ 3 X Widowed 4 ☐ Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Hillcrest Electrical ies 1 and 2 should be filed voll Health and Mental Hygie of Health and Mental Hygie if item 27 ie marked other to other treumatic event, III. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth Cook Annie Mae Gillespie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12905 Brandywine Road, Brandywine, Maryland Tommy Lee Cook Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If its
eny injury or ott 1

Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) December 9, Westview Cemetery Blacksburg, Virginia 2005 21. Signature of Funeral Service License 22. Name and Address of Facility
McCoy Funeral Home, Inc.,
Blacksburg, Virginia24060 150 Country Club Dr., 10 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician entenon, /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physicien end s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death ed by the e 5 Other (specify) P.0 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? After this certificete 1 Yes 2 No 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 DNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural To the nospurer within 24 hours effer death.

To the Funeral Director: Alt 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal (Check only one) nd title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 5047 December, 6,05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE 3-41 Silver Spring MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 9:06P. M Angel Christine Augins 2005 /Medical Dec. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/ABaltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 45 214-78-7082 Yrs Director Jan. 21, 1960 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location r than "naturel", or Iteme 23a or 28e-f ehow the Medicul Example at most by notified at 10d. Inside City Limits Maryland N/ABaltimore X□Yes 2□No Direct 10e. Street and Number 10f. Zip Code 21213 10g. Citizen of What Country? 2520 E. Biddle Street IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status unk. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Spec Black Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 10th grade Manager Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic ever Ada K. Pittman Jack William Augins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Lake Park Ct. Germantown, Maryland 20874 nt of Health a :: If item 27 is Tiffany Leach/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott XIXBurial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 12/13/05 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Internate Cause (Final disease or condition

a. Approximate Interval Between Onset and Death Importate Cause (Final disease or condition resulting in death) Physician Rays /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of the attending physicien and the dor use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown leted peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Compl has this sertificate Vita patitis To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this settifical completely filled in by the funeral director, p Be 25. Was case referred to medica 26. Place of Death Check only one Cther: 4 Nursing Home 5 Residence 6 Sother (Specify) Naspice Hospital: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA sion of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of confide 29c. License number 29d. Date signed (Month, Day, Year) 0005621 win MP nd address of person who completed cause of death (Item 23a) (Type, Print) Hanover St. Salpinere, mo 2125 F. PEWEN, MO 300 31. Date filed (Month, Day, Year) 32. Registre's Signature State DEC 1 4 2005 ▶ Registrar

CPM 05-08319 Herbert Allen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	.0 1220		For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H rtificate of L			ene) () 5	40473
			1. Decedent's Name (First, Middle, La	st)				Date of Death Month		3. Time of Death
	Physici /Medio		Herbert			Allen		December	09, 2005	
*	Examin	er	4a. Facility Name (If not institution, given Johns Hopkins Bay		al Center		Location of Death		4c. County of Deat	ו
	Funeral Director		5. Social Security Number 6. S 212–56–9155	ex 7. Age	(In yrs. last birthday) 52	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4–11–5	Year) 9. Birtl	nplace (State or Foreign untry) Md.
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryia f eho	lor	Md. N	A	Balti					1 XYes 2 □ No
	r 28e-	irect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	23a o	aiD	3105 Cliftmont	Avenue		21	213		USA	
36	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f ehow lited Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2V N If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2√ No	spanic Origin? (Spe n, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
21215-0036	c 2	pieted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa e kind of work done d DO NOT use retired)	luring most of worki	ng 1	6b. Kind of Business/	ndustry
21	e filed within Hygiene.		G.E.D. 17. Father's Name (First, Middle, Last)			Laborer	18 Mather's Name		Domestic V	Vorker
anc	build be fi Mental H arked ot atic ever	o Be	Herbert		Allen, S		18. Mother's Name Nettie	(rirst, Middle, Mi	alden Sumame) Barne	es
Maryland	s 1 and 2 should be Health and Menta tem 27 ie marked other traumatic ev	7	19a. Informant's Name/Relationship (Type, Print)			nd Number or Rura	l Route Number,	City or Town, State, 2	ip Code)
	1 and 2 Health a lem 27 is		Gloria Craighea	d Frie		5 Cliftmo				213
ore	90-		20a. Method of Disposition 1 XBurial 2 Cremation 3		20b. Place of Dispe cemetery, cre	osition (Name of matory or other place	9)		Oc. Location - City or	
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify 21. Signature Funeral Service Licer		-	em. Park 2. Name and Addres	12–16 s of Facility		Randallsto	
Ba	permit. Depertrimporte eny lajiv		Juny to			March F.H	. East		E. North Av	
			23a Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	plidations that caused one cause on each lin	Δ.	otic Co			Λ -	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	a consequence of):	olic W	PSCIONOSCI	alco-	Vistare	
	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b	a consequence of):					
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30,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
68760,		edical		d						
P.O. Box (The law requires that the death certifi sie has been signed by the attending i page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
	es that igned by be deta	by Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	inderlying cause give	n in Part I.		acco use contribute to	
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Vital Records,		Completed						24a. Was an autopsy perform	ed? prior to c	opsy findings available ompletion of cause of
Vita	Physicien: rthis certificatal director, particular	Be	25. Was case referred to medical examiner?	Hospital:	12	ot 3 DOA Othe	26. Place of Death			
ō	g Phys er this eral dir	n: To	1X Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28b. Time o	THE BUILDING	T L I TAUTS IT IS I TOT	ne 5 Residen 28d. Describe how	nce 6 Other (Spec	ify)
ion	Attending For death. ector: After by the funera	atio	1 Accident 5 Pending Investigation	1	Year) Injury		? ′es 2□No			
Division	al or Atter de la Directe de in by t	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fun	Medical C	29a. Certifier 1 Certifying Ph	nysician: To the best on niner: On the basis of and manner sta	examination and/or in	th occurred at the tim evestigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	within To th compl	Me	29b. Signature and little of certifier	\wedge		29c. License	number	290	d. Date signed (Month	. Day, Year)
	X) Uteska	eaw			.C.M.E.	De	cember 10,	2005
1	1		30. Name and address of person who J. Laron Locke				eet, Balt	imore, M	Maryland 21	201
i	Sta Registi		31. Date filed (Month, Day, Year)	.69	r's Signature	Carle				

Physician Modical Examiner As Facility Name (If not institution, give street and number) As Facility Name (If not institution, give street and number) As County of Death As County of D	
Social Security Number Social Security Num	Time of Death
10a. State 10b. County 10c. City, Town or Location 10c. In 10c. In 10c. In 10c. Street and Number 10c. St	(State or Forei
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 19. Informant's Name/Relationship (Type, Print) (wing) 10. Informant's Name/Relationship (Type, Print) (wing) 10. Informant's Name/Relationship (Type, Print) (wing) 10. Informant's Name/Relationship (Type, Print) (wing) 10. Informant's Name/Relationship (Type, Print) (wing) 10. Informant	nside City Limi
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOREOGRAP B. KOTHER 10 NNOTH STATEM STATEMENT BALTMONE MANYLAM 212 State 31. Date filed (Month, Day, Year) 32. Register's Signature of the statement of the s	اما

			1 - For State Registrar	State of M	laryland /				ealth a Death	and M		Reg. No.	05	Services The Servi	0475
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	ter death with the Marylan Iteme 23s or 28s-f show	Director	MD N/A	1	10c. City, To	ALTI			TY			10 000			d. Inside City Limits 1 XYes 2 No
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Maryland 21215-0036	d within giene. or then "	Completed	15. Decedent's E (Specify only highest grades) Elementary/Secondary (0-12)	ducation ade <i>completed)</i> College (1-4or		6a. Deced (Give) life. C	kind of wo. O NOT us	rk done a se retired,	ttion luring most TION	of workii	ng		LABOE		stry
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Baltimore, Mar	ages 1 and 2 should int of Health and Mer t: If Item 27 Is marke y or other traumatic		19a. Informant's Name/Relationship (METTIE CLIFTO 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □	N / WIFE	20b. Place	170 of Dispos	9 MC	CUL.	LOH :	STRE	EET, E ate	BALT]	MORE cation - Cit	E , My or Tow	ID 21217 n, State
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Box 6	ine death certifica y the attending phi tched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pro Other (spe					2.	3d. Date of Month	,	ay Year
	naw requires that the delas been signed by the a 2 should be detached to	Ď	Part II. Other significant conditions of	contributing to death b	out not resulting	g in the un	derlying ca	ause give	n in Part I.		1	tobacco us		te to the	cause of death?
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5	2 2 3 3	Certification:	3 Suicide 6 Could not be determined	building, et	c. (Specify)						City or To	wn, State)			Route Number,
	n 24 hours a	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best niner: On the basis o and manner st	i examination a	ge, death and/or inve	occurred a stigation,	at the time in my opi	e, date and nion, death	l place, a	nd due to the d at the time,	cause(s) a date and p	ind manne place, and	r as state due to th	ed. e cause(s)
	within 2 To the complet	Σ	29b. Signature and title of certifier	ney Mr)			License		660		29d. Date	signed (M	onth, Da	y, Year) 15, 2005
	7		30. Name and address of person who 31. Date filed (Month, Day, Year)	D. Ken	leath (Item 23a		rint)	Uni	on N	remo	ovind i	top	BA	11	MUZIZIE
	Sta Registr			2005 32. Headistr	ar's Signature	A	make	9							

Piease Type or Print in Black indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year James 28 IHEOdore oleman /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth Harpers FT. Washington rive Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, 9. Birthplece (State or Foreign **Funeral** Months Days Hours 1 MM 2 □ F 578-58-6050 Yrs. Director Whiteville Usuel Residence of Decedent 10a. State 10c. City. Town or Location r than "naturel", or items 23a or 28a-1 show the Medical Examiner must be notified at 10d. Inside City Limits mD Director Prince Washington 1 Yes 2 No JEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? States United Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. Peges 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Yes 2 If Yes, Give 2 | No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 2 3 Widowed 4 Divorced Specify: Year or Dates: 1966-68 Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STEMS 5+ Deperment of Health and Mental Hygis Important: If Itam 27 Ia marked other i eny Injury or other traumatic event, # 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be oleman Hanie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) III. 60302 lak tark 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 Removal from State Maryland Ve 12/9/05 Trans 4 ☐ Donation 5 ☐ Other (Specify) heltenham, MD. 21. Signature of Funeral Service/License 22. Name and Address of Facility STREET N.E. DC. 20002 M01178 23a. Part1. Enter the disease, or complications that dauled the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Hypertensive Heat Examiner Due to (or es e consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical es the Due to (or as a consequence of) attending I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 14 Tes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral s after deau.../al Director: After th 27 Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? edical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 A Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral (
completely filled Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 150055 D 20 30. Neme end address of person who comple eted cause of deeth (Item 23e) (Type, Print) nster 001 Ho 31. Date filed (Month, Day, Year) #32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

5 2005

ORIGINAL

Physici		1. Decedent's Name (First, Midd	die Last)							2. Date of Dea	th		3. Time of Death
		Marie Crawfo								Novembe	Day	Ye <i>a</i> r .005	9:03 AM ^M
/Medic		4a. Facility Name (If not institution		ımber)		4b. City, 7	Town, or	r Location o	of Death	NOVELLDE	4c. County		
		Suburban Hos	pital			Rocl					Monte	omer	У
Funeral Director		5. Social Security Number 224-32-5033 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	. last birthday, Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) Feb 27,	Year) 1919	9. Birth Cou	nplace (State or Foreign untry) unk
land ow		10a. State 10b. Count	у	10c. C	ity, Town or L	ocation							10d. Inside City Limits
the Marylan 28a-f ehow	ţċ	MD Mont	gomery		Bethes	da							1 ☐ Yes 2√2 No
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. to other than "natural", or items 23a or 28a-f show orent, the Medical Exandrar must be notified at	Director	10e. Street and Number				10f. Zip					10g. Citizen of \		untry?
ath w	rail	5721 Grosveno			T			20814			US		
ter dea iteme	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed F	edent Ever in lorces?	J.S. 13.	Was Decede If Yes, speci	ent of H ify Cuba	lispanic Ori an, Mexic <i>a</i> r	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Blad	e - Amer k, White	ncan Indian, o, etc.
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aryla should ind Men marks umatic	1	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Numbe	r, City or Town,	State, Zi	ip Code)
and 2		Suburban Hospi	tal		8600	Georg	eto	wn Ro	ad B	ethesda	MD 20	0814	
of He		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from		Place of Dispo cemetery, cre	osition (Nam	e of			Date	20c. Location -		Town, State
Pag ment ment:		4 □ Donation 5 ☑ Other (Specify) in st	ate				i					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or any injury or other treumatic event, the Medical Examplane.		21. Signature of Ameral Service Ronald	S. Wade	recto	E S B	2 Name and tate A altimo	Addres nat re,	ss of Facilit Omy B MD	oard 2120	655 W.	Baltim	ore	Street
Physician		23a. Part1. Enter the disease, shock, onheart failure. List Immediate Cause (Final	or complications that st only one cause on	each line.	ath. Do not en	ter the mode	of dyin	ig, such as	cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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iaw requires thet the death certificates been signed by the attending places should be detached for use as it.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregr birth 2 ☐ Fet nant at time of nown	al death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>		,			23d. Dai Mo		very Day Year
IS, P.O. res that the digned by the	F.	Part II. Other significant condit	tions contributing to o	leath but not re	sulting in the u	inderlying ca	use givi	en in Part I.		23e. Did to	bacco use cont	ribute to	the cause of death?
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Division of Vital F he Hospital or Attending Physician: Th in 24 hours elect death. he Funeral Director: After this certificate pietely filled in by the funeral director, pag	BeC	25. Was case referred to medic examiner?	al	,				26. Place	of Deat	1 ☐ Yes h (Check only or		Tes	2U NO
of Vita Physician: r this certific	To E	1 Yes 2 No			☐ ER/Outpatie	nt 3 DO	A Othe	er: 4 ☐ Nu	rsing Ho	me 5 Reside	ence 6 □Oth	er (Speci	ify)
Division of Vital Records, P.O or Attending Physician: The law requires that the effer cleath. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	ation:	27. Mann of Death 1 atural 5 Pend 2 Accident inves	ing 28a. Date (<i>Mor</i> tigation	of Injury oth, Day Year)	28b. Time o Injury	of 28	C. Injury Work	yat k? Yes 2 □ l		28d. Describe h	ow injury occurr	ed	
DIVIS	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 286. Plac	e of Injury - At I ling, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory,	office			28f. Location (Si City or Town	treet and Numb n, State)	er or Rur	ral Route Number,
Division of Vital Rewithin 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the feature on the terminer: On the terminer	e best of my kn basis of examin oner stated.	owledge, deat ation and/or in	h occurred a vestigation,	t the tim	ne, date an pinion, dea	d place, th occurr	and due to the cred at the time, d	ause(s) and ma late and place,	nner as :	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifi	ier			29c.	License	e number		2	9d. Date signed	(Month	Day, Year)
		1 Let Kill	- MD				0060	117			December	14, 2	2005
		30. Name and address of person Eric Joon-Sk				,	nto	r Noi:		D = -1: 1 1	L MD 4	OOF	2
		DLIC OCCI DI	ik iaik, i	w, 770.	T TICALL	ALL UC	TICCI	- DETA	ve,	KOCKATTI	le, mp 🛚	としめつに	<i>)</i>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Descinba 09 200 **Physician** 12:30 PM HELEN COMEGYS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOUR HOSPITAL 8ALTIMORE
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. NA 5. Social Security Number 6. Sex 8. Date of Birth (Month. Day Birthplace (State or Foreign Country) **Funeral** Months Days Hours 215-18-3483 Director 83 06.13.1922 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "netural", or Items 23e or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director NA 1 XYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 193 GRANILEY STREET 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN COLLEGE OF NOTRE DAME 12 14 GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH NELSON NETILE ROBES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health ALFRED J. DUPPINS SON! 5915 LEYHWALK BALTIMORE MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Surial 2 ☐ Cremation 3 ☐ Removal from State ö Importent: 4 □ Donation 5 □ Other (Specify) ARBUTUS 12.14.05 BALTIMORE, MD 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility UNERAL SERVICES Vangh 5151 BALIO, NATE PIKE, BALTO, MID 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BILATERAL DAYS /Medical Due to (or as a consequence of): **Examiner** ACUTE DAYS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed ARTERIOSCLEROTIC DISTAST burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signad by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HLY PERTENTION 1 Yes 2 No 3 Probably 4 ™onknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? CEREBRO-VASCULAR 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Natural 5 Pending investigation death. 2 Accident 1 TYes 2 TNo the 24 hours after deat a Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. D 23300 December 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130N 3E40 UAS , PATEL SUDNIR . D 2000 W. BALTO ST. BALTO MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Joseph H Sparke Registrar DHMH 17 Rev 1/2001

State Registrar

G.

2005

31. Date filed (Month, Day, Year)

15

DHMH 17 Rev 1/2001

32. Registrar's Signature

111 PENN STREET BALTIMORE MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 05 ixon 30 AM not institution, give stre 4b. City, Town, or Location of Death 4c. County of Death llico Howa If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 212-03-8604 1□ M 2 F Days 10b. County 10c. City, Town or Location 10d. Inside City Limits toward 1 ☐ Yes 2 No mbia 10g. Citizen of What Country? 10f. Zip Code 2104 Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2MNo 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ*NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First Middle Last) | | | | |

Physician /Medical Examiner

Physician

/Medical

10a. State

8900

Director

Completed by Funeral

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any Injury or other traumatic event, the Medical Examplar Inval for collided at once.

Baltimore, Maryland 21215-0036

ettending physicien and for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

To Be	17. 1 auto, 3 Hamo (1 h3t, Middle, L23t)	unk	Cera	Hoffm	en Sumana	. /
	19a. Informant's Name/Relationship (7)	n/Gand Son 8900 N	Address (Street and Nymber or I	Rural Route Number, Cit	y or Town, State, 1D 210	Zip Code)
	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		on (Name of on (Name of place)	Date 20c.	Baltim	Town, State
	21. Signature of Furferal Service Licen	treene 87	and and Address of Facility 28 Liberty Rd	ene Fuher Randalle	/	11003 1110 21133
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	· failure	he mode of dying, Swell as cardi	ac or respiratory arrest,	•	Approximate Interval Between Onset and Death
xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	Tia			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		topic pregnancy ther (specify)		23d. Date of de Month	livery Day Year
ed by Ph		ontributing to death but not resulting in the under	rtying causa given in Part I.	23e. Did tobacc		the cause of death?
Complet	HTN			24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			eath (Check only one)		
ဥ	1 □ Yes 22 No		3□ DOA Other: Nursing	Home 5 Residence	6 ☐Other (Spe	city)
atlon:	27. Manne of Death Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, Sta	and Number or Ri ate)	ural Route Number,
Medical Certification; To	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death or tiner: On the basis of examination and/or invest and manner stated.	ccurred at the time, date and plactigation, in my opinion, death occurred	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
Σ	29b. Signature and title of certifier	- Attending MD	29c. License number 95 330.7	29d. [Date signed (Mont	h, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 5 2005

Rodolto

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

405 Frederward Stellez Catingville, 21228

		•	For State Registrar	State of Maryla			it of Health e of Dea			giene Reg. No	000	40481
·	Physici /Medic	an	1. Decedent's Name (First, Middle, Last	DeVincen	+				2. Date of De Month Pec.	Da	y Year O 200	3. Time of Death $5193H M$
	Examin Funeral Director	CI	219-18-3822	land Medical C		4b. City,	1 Year If Une	der 24 Hrs.	8. Date of Bir (Month, Da 0 2 / 1 3 ,	th ly, Year)	NIA 9. Bir	hth hthplace (State or Foreign ountry) MD
	Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Ari		ity, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No
	a or 28s	I Director	10e. Street and Number 207 Glen Road			10f. Zip	Code 1122				tizen of What C	ountry?
036	hours after death with the Maryland ural', or tleme 23a or 28a-f ehow at Examinar mant be ricitified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Dece	dent of Hispanic cify Cuban, Mexi	ican, Puerto F	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi	
Maryland 21215-0036	within 72 ene. then "nal	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give	dent's Usu kind of wo DO NOT u		nost of workir	ng		ind of Business	inment
and	be filed tal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)	- District			18. Ma		(First, Middle		,	
lary	2 should and N ls mail	P	Emilio Dominic 19a. Informant's Name/Relationship (7)		-	ng Address	(Street and Nur					Zip Code)
	s 1 an of Heal Item 2 other		Mary DeVincent 20a. Method of Disposition Entom 1 Burial 2 Cremation 3	ibment Removal from State	Place of Dispo cemetery, cren	natory or o	ther place)	D	ate	20c. L	21122 ocation - City or	
Baltimore,	permit. Page Department of Important; If eny Injury or page.		4 □ Donation 5 M Other (Specify) 21. Signature of Funeral Service Licens		22	2. Name ar	nd Address of Fa	cility G . J	.Gonc	e F	uneral	nie, MD Home, PA D 21122
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	al I	or the mod	1	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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ords, P	The law requires that the tee been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co End-stage Renal	ntributing to death but not re	sulting in the ur	nderlying o	ause given in Pa	art I.				o the cause of death?
Vital Records,		Completed	25 Was associated to make						1 Yes	psy ormed? 2 Milyo	prior to	utopsy findings available completion of cause of
f Vit	nyslcian: T nis certificat I director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital: 1 7 Inpatient 2] ER/Outpatien	it 3 DC	Other		Check only one 5 Residue		6 □Other (Spe	ocify)
ion of	Attending Physician: r death. ector: After this certific by the funeral director,	atlon:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	28c. Injury at Work? 1 ☐ Yes 2		8d. Describe	how inju	ry occurred	
Division	2 = = =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Spec	nome, farm, str	eet, factor	/, office	2	81. Location (: City or To			ural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	29a Certifier 1 Certifying Phy (Check only one)	ner: On the basis of examinand manner stated.	ation and/or inv	vestigation	at the time, data, in my opinion, o	and plane a death occurre	nd due to the od at the time,	date and	d place, and due	e to the cause(s)
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10	01		30. Name and address of person who co	- 1 P	<4	Print)	11.	e Mi				
	Sta Registi		Mother Kashy, ZZ 31. Date filed (Month, Day, Year) DEC 1 5 20	32. degistrar's Sign		este !	settimore	<u> </u>	2 2	01		

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	pu ,		Usual Residence of Decedent 10a. State 10b. County		10a City	Town or Lo	antina						10d. Inside City	. I familia
	aryla ahov	5		C									1X Yes	
	Ne M	ectc	10e. Street and Number	Georges	0	ollege	10f. Zip Code				10a C	itizen of What Co		
	with t	ä					20740					USA	ountry :	
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lar	2 sh and is m		19a. Informant's Name/Relationship				ng Address (Street						Zip Code)	
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	101		30. Name and address of person wh	3 + 4, A	death (Item	23a) (Type,	Print) Paul	B. Be	endr, l	M.D.	10	e. 14,	82	
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Regist	Har's Signat	ure	Sparke							

		1 - For State Registrar	State of I	Marylan		artment rtificate			and M	fental Hy	giene Reg. No	$J \cup I$	5 4	0483
Division		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		V	3. Time of Death
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Funera Directo		214 80 1650	1 □ M 2 🛣 F	46	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Feb. 1	v. Year)	959	Count	ice (State or Foreign Y) land
pr ,		Usual Residence of Decedent								100. 1	0, 1		1101 9	zand
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with with	Funeral Director	706 W. Main	Street			10f. Zip	217	727			-	U.S.	What Count	ry?
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2 should I and Meni Is marke		19a. Informant's Name/Relations							r or Rura	a <i>l Route Nu</i> m <i>b</i>	er, City o	r Town,	State, Zip (Code)
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor									23d Dat	e of delivery	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** w. GEISE Gerge December 1:18 A M 13 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Glen Burnie Anne Arunde Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F 219 12 9828 80 Maryland Director 14, 1924 Usual Residence of Decedent 1 and 2 should be tiled within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or iteme 23s or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Anne Arundel 1 Yes 2 No Ferndale by Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 Pinetop Drive 21061 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Dispatch Supervisor Trucking 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Geise, Sr. Lillian Christina Germanhauser ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia M. Geise / wife 1014 Pinetop Drive Ferndale, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages . 70 = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. Timonium, Maryland 4 □ Donation 5 □ Other (Specify) Dulaney Valley Cem. 12/16/2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Rant. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Intrac day **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760. attending physical for use as the t IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1' Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Naturaf 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 Tes 2 No 2 Accident investigation Director: / 3 Suicide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) Doca2483 Recember 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 Nospital Dr. Glen Burnie, Mb 21061 JACOBS MD 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Marylan		artmen rtificate			and M	-	giene Reg. No.	1113	40485
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Baltimore,	t. Pages 1 rtment of H rtent; If ite njury or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lice	ify)	te c		natory or of en Mer	n. Pa	ark 1	2/15	,	G1e		e, Maryland
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State of Maryland / Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER 11 **Physician** MARIE GREENWALD 2005 10:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/15/1911 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months 94 NY Director 086-05-1233 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits or 28s-f show other treumatic event, the Medical Examiner treat be notified at 1√Yes 2□No Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Iteme 23a 6210 PARK HEIGHTS AVE. APT. #800 U.S.A. Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. int: If Item 27 Is marked other then "natural", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY TOWEL SUPPLY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **MAISTO** UNOBTAINABLE **ERNESTO** LUCIA 2 Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7630 PARK HEIGHTS AVENUE - BALTIMORE, MD 21208 19a. Informant's Name/Relationship (Type, Print) PATRICIA FISHER / DAUGHTER 20b. Place of Disposition (Name of Camelery, Commatory or other place)
MIKRO KODESH
BETH ISRAEL CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ō Department of Important: If any Injury or once. 12/14/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Euperal Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Uxunom relum disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Gonknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

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the Funeral Dire. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the ţ 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print) 30. Name and adds OIR eman 31. Date filed (Month, Day, Year)

State Registrar

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100	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sagale	- (Privile	1110 7	2(201
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					epartment of Health and		
		•	1 _ State		Certificate of Death	Reg.	000 90902
			Registrar 1. Decedent's Name (First, Middle, Last)		John Marie G. D. Garris	2. Date of Death	3. Time of Death
	Physici /Medic		LOUIS, STOCK	HAUSEN		Month	Day Year 0330 M
	Examin		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Dea	th	4c. County of Death
		*	University of Marylar			10 D-1(Dint	N/A
	Funeral		5. Social Security Number 218-78-3491 6. Sex 1 ☐XM 2 €	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) MD
1	Director		Usual Residence of Decedent	77		12-24-15	OO FID
	ryland		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits 1 Yes 2X No
	Ba-f	Director	MD Anne Arundel	Glen B			
	with th	ä	10e. Street and Number		10f. Zip Code		Citizen of What Country?
	leath ne 23	Funeral	1724 Leisure Lane	s Decedent Ever in U.S.	21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	J.S.A. 14. Race - American Indian,
9	or Item		1 Never Married 2 Married 1 S	ed Forces? Yes 2 No	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White, etc. Specify: White
215-0036	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f show alstal Examinar must be natilied at	dby	3 ☐ Widowed 4 ☑ Divorced Year	es, Give ir or Dates:	To tes 2021No Specify:		
7	"natu	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Decedent's Usual Occupation Give kind of work done during most of wo life. DO NDT use retired)	orking 16b	b. Kind of Business/Industry
212	within lene. then "	dmo	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	curity Guard		Security
d 2	Hygid Other	BeC	17. Father's Name (First, Middle, Last)			ime (First, Middle, Mai	
and and	should be that Mandal M	ToB	Louis Conrad Stockhaus	en, Sr.	Marcel	Lean McDerm	ott
Maryland			19a. Informant's Name/Relationship (Type, Prin		Mailing Address (Street and Number or F		
	1 and 2 Health		Mr. Louis C. Stockhaus		12 Sycamore Rd; Min		MD 21108 : Location - City or Town, State
Baltimore,	iges 1 of of H or of		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Remova	from State cemetery	crematory or other place)		
ij	permit. Pages Department of Important: If I eny injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Chesap	eake Cremation 12-		tevensville, MD
Ba	permit. Departr Importe eny inje) May 1 1/2	med Mo135	d Second Ave SW; (
			23a. Part1. Enter the disease, or complications shock, or neart failure. List only one caus	that caused the death. Do no	ot enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Transit	Brain Injury		Onset and Death
	/Medical		resulting in death)	ue to (or as a consequence o	1):	·	
	Examiner		Sequentially list conditions, b	NUMBER OF STREET	60		
,	ed slt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a nonsequence o	y:		
	be executed ician and burial-transli	xan	that initiated events c.	ue to (or as a consequence o	f):	1 10	, ER
760,	e be executed ysician and e burial-transit	20	d. ===			JU-1	O M CXMMINER
68	law requires that the death certificate es been signed by the attending phys. 2 should be detached for use as the	Physician/Medic			1	ATION APPROVED EN M	io ·
Вох	th cer tendin r use	an/N	23b. was decedent pregnant	es, outcome of pregnancy	3 Ectopic pregnancy	ON APPROVED	23d. Date of delivery Month Day Year
_	e dea the att	Sici		Pregnant at time of death Unknown	5 ☐ Other (specify)	ATIO	Month Day real
P.0	hat th id by I	P.	Part II. Other significant conditions contributing	a to death but not resulting in			co use contribute to the cause of death?
ds,	signed d be del	Completed by	lenote Head	Dim		1 🗆 Yes	2.20 3 Probably 4 ☐Unknown
Sor	w require been si should l	lete		1)		24a. Was an	24b. Were autopsy findings available
Re	0 - 0	d Wo				autopsy performed	prior to completion of cause of death?
of Vital Records,	slcien: Th certificete rector, pag	0	25. Was case referred to medical		26. Place of D	1 ☐ Yes 2 ₽ eath <i>Check</i> only one	10 103 2010
>	Physicien: this certific ral director,	To B	examiner? 1 ★/es 2 No Hospital	: 1 Inpatient 2 □ ER/Out		Home 5 Residence	e 6 ☐Other (Specify)
0 0	ing Pl		1 □Natural 5 □ Pending		jury Work?	28d. Describe how	njury occurred
Division	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	-109/05 6°		28t Location (Street	at and Number or Rural Route Number,
Σ	after a	ertif	4 Homicide determined	Place of Injury - At home, far building, etc. (Specify)	40spiful	City or Town, S	State)
	Hospitel	a C		To the best of my knowledge,	death occurred at the time, date and place		e(s) and manner as stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Examiner: Or one)	n the basis of examination and dimanner stated.	or investigation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	1		1 / and //	1/4/	1m) AU 4176435	D15810 1	Dec 11 2005
	4		30. Name and address of person who complete	d cause of death (Item 23a)	Type, Print)	73 11	21211
1	s. 3% _ c.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	S. Green St	リムけか	3 MLD 21291
Contract of the Contract of th	Regist		nFC 1 5 2005 A	and to the	CALL.		
				Name of the last o			

			For State Registrar	State of	Maryland /	Depa Ce	artment rtificate	of H	ealth a D <i>eath</i>	and M		giene	05	40490
			Decedent's Name (First, Middle, Last)							2. Date of Dea		Meli	3. Time of Death
	Physici /Medio		RUTH	HUCK							Month 12-9-20	005 005	Year	11:30P M
	Examin		4a. Facility Name (If not institution, give	street and numb	ber)		4b. City,	Town, or	Location o	of Death		4c.	County of Dea	
п			Solomon Nursing	g Home			So1	omon	S			(Calvert	
	Funeral		Social Security Number 6. Se		. Age (In yrs. last	birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day 3-10-19	Year)	9. Bir	thplace (State or Foreign
	Director		220-05-0904	M 2₫F	84	Yrs.	WOILIIS	Days	Hours	Will I.	3-10-13	921	Ň	(ID
	P		Usual Residence of Decedent		40- Oh. T									1.2.1
	aryla shov	ايا	10a. State 10b. County		10c. City, To									10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	cto	MD Queen Ar	nes	Stev	rensv	rille				· · · · · · · · · · · · · · · · · · ·			
	or 2	Director	10e. Street and Number				10f. Zip	Code			1	10g. Citi:	zen of What Co	ountry?
	ath w	40	411 Victoria Way					666				USA		
	tems	Funeral	11. Marital Status	Armed Force		13.	Was Deced f Yes, spec	ent of Hi ify Cubar	spanic Orig n, Mexican	gin? (Spe 1, Puerto	cify Yes or No- Rican, etc.)	1	 Race - Ame Black, Whit 	
36	within 72 hours atter death with the Maryland ene. than "naturel", or items 23s or 28s-f show the M. cical Examinatin that be multified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐Yes 2 If Yes, Give			1 ☐ Yes 2	No No	Specify:				Specify: Whi	ite
00	ural.	D		Year or Dat		2- 0	to alla Ula					101 10		
7	n 72	Completed	15. Decedent's Edu (Specify only highest grad		"	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most	t of worki	ng	160. Kir	nd of Business	rindustry
12	withi ene. than	Ē	Elementary/Secondary (0-12)	College (1-4	lor 5+)		emake					Ho	me Owne	r
2	be filed within 72 hours after death with the Marylan ital Hyglene. ed other than "natural", or items 23a or 28a-1 show event, the Macical Examinating at		17. Father's Name (First, Middle, Last)				iomario		18. Mothe	r's Name	(First, Middle,			
an	2 should be filed withir and Mental Hyglene. Is marked other than surmatic event, the M.	o Be	Ferdinand A. Korge								ne Lang			
<u> </u>	though Me Me mark mark	၉	19a. Informant's Name/Relationship (T		1	9b. Mailir	na Address	(Street a			l Route Number	r City or	Town State	Zin Code)
Maryland 21215-0036	d 2 s th ar t7 is trau		Mr. Paul B. Huck				-				ensville			
é,	1 an Heal em 2		20a. Method of Disposition		20b, Place	of Dispo	sition /Nam	e of	- 1				cation - City or	
Baltimore,	ages nt of t: If it		12⊠Burial 2 ☐ Cremation 3 ☐ I		ate	-	natory or ot			0 17				
臣	it. P.		 4 □ Donation 5 □ Other (Specify) 21. Signafure of Funeral Service Licens 	<u> </u>	Meado						-2005 Ingleton			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evone.		21. Signature of Fulleral Service Cours	M	101364						len Burr			
		123	222 Part Enter the disease or come										MD 210	Approximate
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition										Interval Between Onset and Death		
	Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	a	gar	KIN	30~	2	0	KIJ	eus			
	/Medical Examiner		Todaking in dodain	Due to (or	r as a consequent	ce of):							1	
		_	Sequentially list conditions, if any leading to immediate. Due to (or as a consequence of):											
$\overline{}$	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Ever unsarying Cause (Disease or injury)											
	and and I-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequenc	ce of):		-	-				_	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ᄪ		17 (
87	cate phys	dlcal		d							-			
9 X	leath certific attending p	Physician/Me	IF FEMALE:	23c If yes outco	me of pregnancy								04 Date -4 4-1	
Вох	atten for u	ian	in the past 12 months?	1 ☐ Live birt	h 2 Fetal dea		Ectopic pre					2	3d. Date of del Month	Day Year
o.	t the de by the tached	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9 Unknow		3.	J Other (Spe	icity)						
<u>α</u>	that the		Part II. Other significent conditions co	ntributing to dea	th but not resulting	o in the u	nderlying ca	use aive	n in Part I.		23e. Did tol	bacco us	se contribute to	the cause of death?
Vital Records,	uires sign	1 by					, ,				1 🗆 Ye	es 20	BNo 3□Pr	obably 4 []Unknown
Ö	w requ	etec										_/		
}ec	e law has t	Completed	-								24a. Was a autops	sy	24b. Were au prior to death?	topsy findings available completion of cause of
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of	Physician: this certific ral director,	은	T Yes 25-dp	Hospital: 1 ☐ Ing					4 X Au	_	ne 5 ☐ Reside			cify)
Ē		Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Month,	Day Year) 28t	o. Time of Injury		C. Injury Work	?		8d. Describe ho	ow injury	occurred	
sio	o sta	cat	2 Accident investigation 3 Suicide 6 Could not be				M		es 2□N	1				
Division	or At fter o pirec	Ħ	4 Homicide determined	28e. Place of building	f Injury - At home, , etc. <i>(Specify)</i>	tarm, str	eet, factory,	office		2	8f. Location (St City or Town	reet and n, State)	l Number or Ru	ıra/ Route Number,
	urs a urs a rai D			1						-				
	Hospital or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune	lica	29a. Certifier (Check only 2 Medical Exemi	ner: On the bas	is of examination	and/or in	occurred a restigation,	it the time in my op	e, date and inio <mark>n, de</mark> at	d place, a th occurre	nd due to the ca d at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
	To the Hospital or Atte within 24 hours after de To the Funeral Directe completely filled in by th	Medical	one) 29b. Signature and title of certifier	and manne	stated.				number				signed (Montl	
	T × O	-	200. Orginataro arra tino di continoi	11/1	1 te	pm	250.)		77	747 "	Ju. Date	Ja /	1. Day, 10ai)
	3		y young	10				1		16	014		12/1	(1)
	2		30. Name and address of person who				-	-1	07.5	MD 0	0600			
			Joseph J. Barth, 31. Date filed (Month, Day, Year)		P.O Bo		20, 30	OTOW	ons,	гш <i>)</i> Z	0008			
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State Registrar 31. Date filed (Month, Day, Year)

ORIGINIAL

			1 = State Registrar			tificate of L			iene 05	40492	
-3	Physici	an	1. Decedent's Name (First, Middle, L	· ·				2. Date of Dea Month		3. Time of Death	
NE S	/Medic		Edi				Decembe	er 12 20	05 9:50 A ^M		
	Examir	er	4a. Facility Name (If not institution, g.				Location of Death		4c. County of E		
	- 4		11991 Carroll M 5. Social Security Number 6.		a land hindhola il	If Under 1 Year	ott City If Under 24 Hrs.	0.0-1(0:4)	How		
τ.	Funeral Director		218 42 4870 Usual Residence of Decedent	18 M 2 F 59	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept 18	3, 1946	Birthplace (State or Foreign Country) Maryland	
	and ow		10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits	
	with the Maryland a or 28a-f show	to	MD Howard	a .	Ellicot	t City				1 ☐ Yes 2 No	
	r 28a	Director	10e. Street and Number	<u>.</u>	DITTECO C	10f. Zip Code		1	0g. Citizen of Wha	: Country?	
	th wit	aiD	11991 Carroll M	ill Road		21042	2		United	States	
21215-0036	or items	by Funerai	11. Marital Status 1 Never Married	12. Was Decedent Ever in Armed Forces? 1	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	merican Indian, thite, etc. White	
9	72 hours naturel', dicel Ex	ted	15. Decedent's 8	Education	16a. Decede	ent's Usual Occupa	ation	400	16b. Kind of Busine		
21	C _ 4	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired,)	ong			
2		Co	12		Soft	ware Tech			Northrop	Grumman	
⊆ .	₩ ₩ ₩ ₩	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam		Maiden Sumame)		
2	should be nd Mental marked	ို	Edmund E. Hagan 19a. Informant's Name/Relationship		AOF MARIE		Florence				
Ma	nd 2 sho alth and 27 le m				100				City or Town, Star		
ည	Hei Hei		Nancy L. Hagan/V 20a. Method of Disposition	20b.	Place of Dispos	ition (Name of			20c. Location - City	MD 21042 or Town, State	
2	ages ant of nt: If i		Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	LIMemoval from State		atory or other place	. 1		,	sville, MD	
Baltimore,	permit. Pages Department of Important: If i eny injury or o	- 1	21. Signature of Funeral Service Ligh							mily FH Inc.	
ä	Depa Impo eny id		I Sham Coll	is- Nette	411	12 Old Co	lumbia P	ike Elli	cott City	7, MD 21043	
	\$		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused the dea						Approximate Interval 8etween	
y F	Physician		Immediate Cause (Final disease or condition	Colm	Cano					Onset and Death	
1	/Medical		resulting in death)	Due to (or as a conse	equence of):					37	
1	Examiner	_	Sequentially list conditions,	b							
/ 1	ed sit	iner	d any leading to immediate cause. Enter Underlying Cause (Disease or injury	Directo (or as a consequence of):							
<i>V</i>	xecut and al-trar	Examin	that initiated events	C							
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	ding se as	n/Medicai	IF FEMALE: 23b. Was decedent pregnant	d	nancy				23d. Date of	delivery	
\sim	ath certif	ician/Medicai	IF FEMALE:	d	nancy tal death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
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Please Type or Print in Black Indelible Ink. Ensure A	II Copies Are Legible.
State of Maryland / Department of Health and N	Mental Hygiene 05

	•	State of Maryland / Department of Health and Me 1 - State Registrer Certificate of Death	ntal Hygie	4000	40493
Physicia	in	1. Decedent's Name (First, Middle, Last) THADIOUS A. JONES	Date of Death Month	Day 0 2 Year	3. Time of Death
/Medic Examin	- 6	4a. Facility Name (If not institution, give street and number) University of Mary and Medical Center Baltimore	WE	4c. County of Death	
Funeral Director			Date of Birth (Month, Day, Ye 03/06/	9. Birth Co. 1935 N.	pplace (State or Foreign untry) CAROLINA
Maryland -febow	lor	10a. State 10b. County 10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits 1X Yes 2 □ No
with the	Direc	10e. Street and Number 1947 W. FAYETTE STREET 10f. Zip Code 21223	10g.	. Citizen of What Col	untry?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after deeth with the Maryland feath and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f ehow other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never M	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: BI	e, etc.
21215-0036 ad within 72 hours af giene. er then "natural", or er then "natural".	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) STH 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) ELECTRONICS	В.	b. Kind of Business/I ALTIMORE OODWILL	
yland 2 ould be filed Mental Hygic arked other attic event,	Be	17. Father's Name (First, Middle, Last)		iden Sumame) LEOD	
Maryland nd 2 should be fill lith and Mental H; 27 is marked out	10	19a. Informant's Name/Relationship (Type, Print) CATHERINE M. JONES/WIFE 19b. Mailing Address (Street and Number or Rural Page 1947 W. FAYETTE STR	Route Number, C	ity or Town, State, Z	
Baltimore, M permit. Pages 1 and Department of Health important: If item 27 any injury or other transcene.		20a. Method of Disposition 1 Description 1 Description 20b. Place of Disposition (Name of complete place) 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of complete place) 4 Description 20b. Place of Disposition (Name of complete place) 4 Description 20b. Place of Disposition (Name of complete place) 4 Description 4 Description 20b. Place of Disposition (Name of complete place) 4 Description 4 Description 4 Description 4 Description 5 Description 4 Description 5 Description 6 Description 6 Description 6 Description 7 Description 6 Description 7 Description 6 Description 7 Description 8 Description 9 Description 1 D	5/05 O	WINGS MI	LLS, MD
Balt permit Depart import any ini once.		21. Signature 17 eral Service Licensee 22. Name and Address of Facility HOW 4600 LIBERTY HEIGHT	HTS AV	E., BALT	ME 21207 'IMORE, MD
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Examiner	ner	Sequentially list conditions.			
68760, Cificate be executed physician and and is the burial-transit	Physician/Medical Examiner	resulting in death) Last Due to (or as a consequence of):			
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of Vital F Physician: Th this certificate ral director, pag	To Be	examiner?		e 6 □Other (Spec	afy)
iton of			d. Describe how i	injury occurred	
Division if or Attendit after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral bifector: A completely filled in by the fo	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	doug to the name I at the time, date	and place, and due	to the cause(s)
To the withing To the transfer committee the	Σ	29b. Signature and title of certifier MD. 29c. License number 16689		Date signed (Month	and the second s
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CNI-Na Pak 22 S. Greene St. Baltimore, MD 217	201		200
Sta Registr	PT	31. Date filed (Month, Day, Year) DEC 1 4 2005 32. Rigistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** December 11,2005 9:00a Kenee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore Date of Birth (Morth, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 50 110 Director Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f ehow or other traumatic event, the Medical Exactions must be notified at 1 Yes 2 □ No JUKSON, DEDDIE Maryland 21215-0036 Saltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6611 USA 21207 or Iteme 23a by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. ☐Yes 2V No Yes, Give 1 Never Married 2 ☐ Married 1 Yes 2 No Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced lack "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use thred) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) oordinator 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental F 19b. Mailing Address (Street and Number or Rural Route City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pfint) permit. Pages 1 and 2 Department of Heelth an Important: If Item 27 Is eny Injury or other trau 1 and 2 Mothe olumbia Viola 20c. Location - City or Town, Slate 20b. Place of Disposition (Name or centetery, crematory or other Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Woodlawn 21. Signature of Euneral Se Services 2/133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in dealh) YEOK **Physician** /Medical menmontis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing is doubt) a set. Due to (or as a consequence of) use as the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the all o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 Probably 4 Unknown 1 Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of dealh? 24a. Was an autopsy perform 21 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 1 Inpalient 2 ER/Outpatient 2 1 Tes 3 DDA 5 Residence 6 ☐Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: after death.
I Director: After d in by the funera ivision 1 | Natural 2 | Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C Hoepital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29b. Signatus 29c. License number 29d. Date signed (Month, Day, Year) 569 N. Charles St. Baltmare 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2005

Damien Johnson 05-08326 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar Amend Item	State of Mary #19b per FH	and / Depa G850 <u>J</u>.2 4	artment of He ₩₩₩	ealth and M Death		jiene 005	40495
			Decedent's Name (First, Middle, La					2. Date of Dea		3. Time of Death
	Physici /Medio		HOD . A MAIMAG	USON				Decemb		
4	Examin		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, or I	Location of Death		4c. County of De	ath
			University of Man	ryland Medica	1 Center	Baltimo			N	4
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) (rthplace (State or Foreign Country)
١.	Director		214.12.5186	19	Yrs.			09.21.10	186	MD
	and *		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Aaryi eho	ō	MD ANNE AT	PHAIDEL G	LEN BUR	AUF				1 ☐ Yes 2 🗹 No
	28a-	Director	10e. Street and Number	CONTRA		10f. Zip Code			log. Citizen of What C	Country?
	3a or	0	406 BURWOOD AVI	FNUF.		21061			ABU	
	ier deeth with the Marylan items 23a or 28a-f ehow ner must be molified at	Funeral	11. Marital Status	12. Was Decedent Ever		Vas Decedent of His	panic Origin? (Sp	ecify Yes or No-	14. Race - Am	
S	or ite	Ē	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		f Yes, specify Cuban		Hican, etc.)	Black, Wh	
Ö	Sin Table	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2M⊆No	Specify:		Specify: B	LACK
21215-0036	within 72 ho piene. r then "netur the Madical	Completed	15. Decedent's E (Specify only highest gra		(Give	lent's Usual Occupat kind of work done du	uring most of work	ing	16b. Kind of Busines	s/Industry
21	within then then	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired) GUARD			RECREATIO	a l
2			12 TH GRADE 17. Father's Name (First, Middle, Last	NA	LIFE		18 Mother's Name		Maiden Sumame)	10
and	b d fa	Be	RUSSEU JOHNSON			1	JOYCELYN			
Maryland	d 2 should b th and Ment ?7 le marked treumatic e	5	19a. Informant's Name/Relationship (19h Mailin				r, City or Town, State,	Zin Code)
Ma	2 6 2 5		JOYDELVAL JONES	(MOTHER)	406 E		111		21061	
<u>6</u>	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition	20	b. Place of Dispo		, ,	Date	20c. Location - City of	r Town, State
e E	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		CING PAR		12.16	.05	RANDAUSTON	OM UN
Baltimore,	permit. Pages 'Department of himportant: If ite any injury or of once.		21. Signature of Foneral Service Lice		22	Name and Address	of Eacility			410 1110
m	9 9 E 9 G		Dangton C	H	VA 519	UGHN C. GRI TI BAUTO NA	EENE HUNE 11. PIRE 1	kal sekui Baim. Mi	21229	
			23a. Part1. Boter the disease, or com shock, or heart failure. List only	plications that caused the						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Y	11) Iti	ole is	Muri	ei		Onset and Death
	/Medical		resulting in death)	Due to (or as a cor	sequence of):		1000	<u> </u>		1
	Examiner		Sequentially list conditions	b						
7	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):					
V	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	coguesco of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	aiE		200 10 (01 03 0 001	soquorico ory.					
687	phys phys s the	dicai		d						
	leath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of pre					23d. Date of de	elivery
Вох	death atter	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnancy Other (specify)			Month	Day Year
o.	t the de by the a	hys	9 Unknown	9□ Unknown						
σ.	res that igned to be det	by P	Part II. Other significant conditions of	contributing to death but not	resulting in the un	nderlying cause giver	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ĕ	v require been sig should b	ed						1 🗆 Y	es 2 No 3□F	Probably 4 Unknown
Vital Records,	aw requas been 2 shoul	Completed						24a. Was a		utopsy findings available completion of cause of
Ĕ		E						perfor	med? deam? 2□No 12Ye	
ita	sician: Th certificate irector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only or	10)	
of \	Şir.	ဂ္	1√2√Yes 2 □ No	222	2 ER/Outpatien		4 Hursing no		ence 6 □Other (Sp	ecify)
Ē	ing P	ü.	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Mpnth, Day Yea	z) 28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurred	1
Sic	Attending it death. ector: After by the fune	cat	2 Socident investigation 3 ☐ Suicide 6 ☐ Could not b	10/1/03	2301	M 1 7		11 leg	treet and Number or F	uccident
Division	tal or Attending Pi s after death. al Director: After ti ed in by the funera	Certification;	4 Homicide determined	28e. Rlace of fnjury - building, etc. (Sp	pecify)	eet, factory, office		City or Town	n, State)	261
ш	Hospital 24 hours 8 Funeral I tely filled		29a. Certifier 1☐ Certifying Ph	ysicien: To the best of my	knowledge death	occurred at the time	a date and place	and due to the c	000 7341	or estated
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by t	Medicai		niner: On the basis of exar and manner stated.						
	To the within 2 To the comple	§ S	29b. Signature and title of certifier	2 ~		29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
-			1 (O Sork	eall		OCME			December 1	0 2005
	5		30. Name and address of person who	completed cause of death	(ftem 23a) (Type,				pecemper I	0, 400)
_	1		JARON LOC	K FMO		111 Penr	Street	Baltim	ore, Maryl	and 21201
	Sta		31. Date filed (Month, Day, Year) DEC 1 5 200	32. Registrar's S	ignature					
	Registr	ar	DEGINATOR	IN STATE SELVE I	Service of the servic	Andrew				

Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2a,27,28a-f, perff.,6851,1/5/06 II
State of Maryland / Department of Health and Mental Hygiene 0 5 Dondi Johnson 05-08255 40496 N.JM 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 Physician A. JOHNSON DONDI December 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Baltimore n/a Sinai Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**⊠**M 2□F Yrs. MD 215.70.6033 Director 08.19.1962 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No MD NA BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 6616 BRIGHTON AVENUE 21215 usa death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Never Married 2 ☐ Married ٥ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK "natural". Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER HOME IMPROVEMENT 1214 GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) UNK 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill timent of Heelth and Mental H tant: If Item 27 is marked oth jury or other traumatic aven JAMES BUILER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENIFER 6616 BRIGHTON AVE., BALTIMORE CARLA MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 12-16-05 OWINGS MIUS, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BALTO. MO ▶ 2 austin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Complications of neck injury /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): ed by the attending physicien detached for use as the buria Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? att 1 X Yes this certificate 2□ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1
☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 3□ DOA Certification: To 28d. Describe how injury occurred Passenger in police van that fell off during a funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death After 1_Natural 5 Pending death. 1 ☐ Yes 2 No 2X Accident investigation 11/23/2005 unk Director: 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide To the Hospital o within 24 hours aff To the Funeral DI street unk 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. e and title of certifier 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year)

Medical

State Registrar 31. Date filed (Month, Day, Year)
DEC 1 5

,WI)

32. Pagistrar's Signature

of death (Item 23a) (Type, Print)

O.C.M.E.

111 Penn Street, Baltimore, Maryland

December 8, 2005

			State Registrar Amend Item #26		artment of Health and I		iene 05	10497
	Dhysici	20	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
*	Physici /Medic		EARL LAWRENCE	JENKINS JR.		12-12-		04:15 A ^M
	Examir	ner	4a. Facility Name (If not institution, give street ar	•	4b. City, Town, or Location of Death	h	4c. County of Death	ו
			405 Forest Valley Dri	Ve 7. Age (In yrs. last birthday	Forest Hill If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Harford	nplace (State or Foreign
н	Funeral Director		213-38-8090		Months Days Hours Min.	(Month, Day, 9-18-1	Year) Cou	untry)
			Usual Residence of Decedent				7.2	
	ahow Let	_	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	889-f.	Sct	MD Worcester	Berlin		1.		
	with th	ă	10e. Street and Number		10f. Zip Code		0g. Citizen of What Cou	untry?
	s 23	era	79 Skipjack Circle	Decedent Ever in U.S. 13.	21811 Was Decedent of Hispanic Origin? (S		U.S.A.	ican Indian
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28e-f show event, If a Medical Exercit at final by Dictilized at	by Funeral Director	1 Never Married 2 Married 1 M	Yes 2 No s, Give r or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	o Rican, etc.)	Black, White Specify: Wh	, etc.
21215-0036	2 hou	ed	15. Decedent's Education	16a. Dece	edent's Usual Occupation		16b. Kind of Business/l	ndustry
715	within 72 lene. than na	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Collete	eted) (Give life.	e kind of work done during most of wor DO NOT use retired)	king		
217	d with giene.	mo.	12		& Fender Repair		Automotive	
힏	al Hygie d other vent, u	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, M	Maiden Sumame)	
<u>yla</u>	should be filed and Mental Hygie marked other umatic event, II	ဥ	Earl Lawrence Jenkins			ret Barte		
Maryland	2 sho and Is mu reum		19a. Informant's Name/Relationship (Type, Prin		ing Address (Street and Number or Ru			ip Code)
	s 1 and 2 should of Health and Men Item 27 is marke other treumatic	1	Mrs. Bunnie Jenkins / 20a. Method of Disposition	Wife 79 20b. Place of Disp	Skipjack Circle;		MD 21811 20c. Location - City or 1	Town State
סר	00-		1XXBurial 2 ☐ Cremation 3 ☐ Removal	from State cemetery, cre	matory or other place)			
Baltimore,	permit. Pag Department Importent: I eny injury o		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		w Memorial Pk. 12- 2. Name and Address of Facility Si			
Ba	permit. Pag Department Importent: I eny injury o		Durer Callas	11101364	l Second Ave SW; (Glen Burn	ie, MD 210	61
	Pnysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not en on each line.				Approximate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions, b. Di cause. Enter Underlying	ue to (or as a consequence of):				one month
8760,	cate be executed obysician and the burial-transit	ledical Examine	Cause (Disease or injury that initiated events c.	ie to (or as a consequence of):				
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	very Day Year
ds, P.	uires that l signed by lld be deta	ρ	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause given in Part I.	23e. Did tob	acco use contribute to	
Vital Records,	The law requir ate has been si page 2 should I	Completed				24a. Was ar autopsy perform 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
ital		Bec	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one		n"s
o	Attending Physicien: r death. ector: Atter this certific. by the funeral director.	은	1 ☐ Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury (Month, Day Year) 28b. Time of Injury		ome 3 Theside 28d. Describe hor	nce 6 Mather (Speci w injury occurred	residence
Division	To the Hospitel or Attendion within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 28e.	Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rur , State)	ral Route Number,
	he Hospil in 24 hour he Funeri pletely fille	edical	(Check only 2 Medical Exeminer: On	o the best of my knowledge, deal the basis of examination and/or in manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as a ite and place, and due	stated. to the cause(s)
)	To t withi To t	Σ	29b. Signature and title of certifier		29c. License number $D 54 84$		ed. Date signed (Month.	Day, Year)
	10		30. Name and address of person who completed Dr. Ashkan Bahrani, M	D 602 South Atw	ood; Belair, MD 2	1014		
	Sta Registr		31. Date filed (Month, Day, Year) DF C. 1 5 2005	32. Registrar's Signature	,			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #7&* Per FH G850 12/15/05 Gartificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month Dey (0:10 AM December Lula Jackson 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) **Baltimore** N/A Future Care--Charles Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 1921 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Deys 1 □ M 2 🛛 F 84 258-38-8178 Mar 14, 2005 Georgia Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 DWYes 2 □ No Baltimore N/A Maryland 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S.A. 21201 819 West Saratoga Street Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Ollie Hollins Charles Hollins 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 7410 Brixworth Court - Apt 102 Baltimore, Maryland 21244 Catherine Patterson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 12/16/05 Brooklyn Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Mausoleum 22. Name and Address of Fecility 21. Signature of Funeral Service Licen Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Pert1. Enter the disease, or communications that caused the fleeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final diseese or condition resulting in death) end STAGE renal d 15CASE Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): ontribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No her (Specify)

Physiclan/Medical Examiner To the Hospital or Attending Physician: The law raquires that the despital or Attending Physician: The law raquires that the death certificate be executed Director. After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Be Completed by Certification: To r daath.

Par

25

27

29a. Certifier

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

2

Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28e-f show

Department of Health Important: If Item 27

Physician

/Medical

Examiner

Baltimore, Maryland 212

other traumatic event, the Medical Expirimer must be nothed at

t II. Other significant conditions of		23b. Did tobacco use contribute to the cau			
		Failure		24a. Wes en autopsy performed?	24b. Were autopsy finding available prior to completion of caus of death?
peripheral	VASCUL AV	DIGEASE		1 Ves 1010	1 □ Yes 2 ŪNo
Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetient 3 0	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigetio	28a. Date of Injury (Month, Dey Year)	28b. Time of fnjury	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined			281. Location (Street and Number or Rurel Route Numbe City or Town, State)		

State

Registrar

fillad in by within 24 hours after or To the Funeral Direct completely fillad in by

31. Dete filed (Month, Day, Year)

Mall

Don m. D

29b. Signature end title of certifier

5901 novih CHAVIES 32. Registrer's Signature

5 2005

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D35102

Street

29d. Date signed (Month, Dey, Year)

Baltimore mary land.

December 12, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 20b per fb 9850 12-23-05 vt State of Maryland Department of Health and Mental Hygiene Common Comm 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2005 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Baltimore If Under 1 Year If Under 24 Hrs. uture 7. Age In yrs. last birthday) a `e 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Months Hours Min. 1 🛛 M 2 🗆 F 18-574 Yrs. lennes Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits timore 1 Yes 2 No Maruland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 2 IEW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DD NDT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) han Marine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sei her ဂ 19a. Informant's ame/Relationship (Type, P nt) Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IVet Ho. Ma. 21229 James Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12-23-05 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Crematory * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Cility 21. Signature of Funeral Service Licensee Joseph L. Russ fu Funeral Frenchise. Balto. Home, 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shdck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URINAR ADDER CINOM MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown THYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? ZHEIMER'S DEMENT 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner The law requires that the death certificate be executed

permit. Page Department of Important: If any injury or once.

Funeral

Director

r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at

iges 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. : If feen 27 is marked other than "natural, or flee or other traumatic event, it is Medical Exurin

Pages

Baltimore, Maryland 21215-0036

with the Maryland

death v

Examiner ed by the attending physician and detached for use as the burial-transit Physician/Medical Completed by has funeral director, Be Certification: To After death.

of Vital Records, P.O. Box 68760,

Division or Attending

after death Director:

within 24 hours a To the Funerel C completely filled

To the

filled in by

Medical

1 ☐ Yes 2 🔼 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 | Homicide

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

↑☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

ana! -uld

5 2005

D18362

29c. License number

12-14-2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3455, Wilkens KDANGMD KOMAL

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

Ave. Suite 308. Balto Md21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 5:49 P M Kidd Duane G. December 6, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director 389-42-4849 62 August 20, 1943 Wisconsin Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits of other than "natural", or iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Virginia Fairfax Vienna Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 9842 Marcliff Court 22181 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I MYes 2 □ No 1967— If Yes, Give Year or Dates: 1976 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Security Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill ont of Health and Mental H it: If item 27 le marked ott y or other traumatic even Be Glen Duane Kidd Ardys Elizabeth Wardwell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis R. Kidd/brother 1591 Highway 166, Caney, Kansas 67333 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State December 14, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2005 Bethesda, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockvi 300 W. Montgomery Avenue, Rockville, MD Rockville, Inc. MUMlam U. Tun _M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Malignant Cardiac Arrythmia 20 minutes resulting in death) /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): Examine and burial-tran Due to (or as a consequence of): Physician/Medical the attending p for use es IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s certificate hes 2X No 1 ☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1∭ Yes 2 ☐ No 2 X ER/Outpatient 3 DOA this After this funerel d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending To the numbers of the death.

To the Funerel Director: Al 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 72 hours after

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Pages

certificate be executed

Box 68760.

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Records,

Division of Vital Attending Physician:

The law

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To the Hospitel

Baltimore, Maryland 21215-0036

State

Medical

20a Cartifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month (Par)

15.

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Registrar

3

32. Registrar's Signature

1 X Certifying Physician: Tu the best of my knowledge ideath occurred at the time, date and clade, and due to the cause(s) and diametrize stated,

Paul B. Baker, M.D., Holy Cross Hospital, 1500 Forest Glen Rd., Silver Spring, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D3511

29d. Date signed (Month, Dav. Year)

December 6, 2005